

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00763

793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>2 1/2 hrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Henrico, Md.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	e. STREET ADDRESS <i>13013 Bananadr.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Margaret Elizabeth Ambrose</i>	First <i>Margaret</i>	Middle <i>Elizabeth</i>	Last <i>Ambrose</i>				
4. DATE OF DEATH <i>1 3 1957</i>	Month <i>1</i>	Day <i>3</i>	Year <i>1957</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 26 1894</i>				
9. AGE (In years lost birthday) yrs. <i>64</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>-</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
13. FATHER'S NAME <i>Edward R. Thompson</i>	14. MOTHER'S MARRIED NAME <i>Ella Virginia Beck</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>-</i>				
17. INFORMANT <i>Virginia A. Hudson, 5013 Bananadr.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>-</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>-</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	20f. (City or town) <i>-</i>	(County) <i>-</i>	(State) <i>-</i>
21. I certify that I attended the deceased from _____, 1954, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Morris Perry</i> M.D. ADDRESS (Street, city or town, state) <i>1602 Georgia Ave. Silver Spring, Md.</i> DATE SIGNED <i>1-3-59</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-7-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Ceme.</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State) <i>-</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Md.</i>	ADDRESS <i>-</i>	24a. REC'D BY REGISTRAR <i>JUL 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>-</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DELAWARE
CERTIFICATE OF DEATH

NAME AND ADDRESS OF DEATH-INSTITUTE

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

00764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. STREET ADDRESS 16332 2705 Bellevue Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ruby		First	Middle	Lost	4. DATE OF DEATH Amburgey	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 31, 1930	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Woodrow Amburgey		14. MOTHER'S MAIDEN NAME Arminita Combs							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Caarcinoma of the ovary with metastasis</i>						INTERVAL BETWEEN ONSET AND DEATH 1y			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) The Clinical Center	
								(County) (State)	
21. I certify that I attended the deceased from January 6, 1959 , to January 30, 1959 , that I last saw the deceased alive on January 30, 1959 , and that death occurred at 7:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>James M. Marsh</i>		M.D.		ADDRESS (Street, city or town, state) The National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1-31-59			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-59		22c. NAME OF CEMETERY OR CREMATORIUM Amburgey		22d. LOCATION (City, town, or county) Hindman Ky.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Son, Inc. of MD. Wal DC		ADDRESS 4400 Clarendon		24a. REC'D. BY REGISTRAR FEB 3 '59		24b. REGISTRAR'S SIGNATURE Arthur & sons			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00765

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida		b. COUNTY Monroe			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Key West		d. STREET ADDRESS 48 x 3 514 E. Flagler Apt.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Doris Louise ANDREWS		First	Middle	Last	4. DATE OF DEATH January 21	Month	Day	Year 1959	
S. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-5-20	9. AGE (In years last birthday) yrs. 38	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Everett STICE				14. MOTHER'S MAIDEN NAME Arenda KLEIN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH appr. 1 yr.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Carcinoma, sigmoid colon					
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, NNMC		20f. (City or town) Keokuk		(County) Iowa	(State)
21. I certify that I attended the deceased from December 19, 1958 to January 21, 1959 , that I last saw the deceased alive on January 21, 1959 , and that death occurred at 3:37 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Larry J. Hines</i>				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 1-22-59			
PHYSICIAN'S NAME (Type) Larry J. HINES, LCDR, MC, USN		Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORIUM Unknown		22d. LOCATION (City, town, or county) Keokuk		(State) Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward S. Adams</i>		ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC		24a. REC'D BY REGISTRAR DATE JAN 26 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hassell</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14 DEZEMBRO - INÍCIO DO INVERNO E FIM DA QUINTA

ATAS DO STADÔITRÉ

1960

1960-01-01

1)

DATA	ATIVIDADES	RESUMO
1960-01-01	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-02	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-03	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-04	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-05	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-06	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-07	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-08	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-09	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-10	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-11	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-12	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-13	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-14	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-15	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-16	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-17	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-18	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-19	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-20	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-21	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-22	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-23	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-24	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-25	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-26	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-27	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-28	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-29	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-30	INÍCIO DO INVERNO	INÍCIO DO INVERNO
1960-01-31	INÍCIO DO INVERNO	INÍCIO DO INVERNO

2)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00766

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York		b. COUNTY Kings	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York - Brooklyn		d. STREET ADDRESS 1758 56th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Mary	Middle Magdalena	Last ATORIA	4. DATE OF DEATH Month January	Day 8	Year 1959
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5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 12-17-58	9. AGE (In years last birthday) yrs. 22	IF UNDER 1 YEAR Months 22	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (State or foreign country) Guantanamo Bay, Cuba	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Joseph A. ATORIA	14. MOTHER'S MAIDEN NAME Margo MARQUE	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT Official Navy Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Cyanotic heart disease, congenital Pulmonary stenosis</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **December 23, 1958**, to **January 8, 1959**, that I last saw the deceased alive on **January 8, 1959**, and that death occurred at **9:10A M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>H. L. Walton</i>	M.D. U. S. Naval Hospital, NMMC	1-9-59
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PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN	Bethesda, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>	ADDRESS 4748 Wisc. Ave., NW, Washington, D. C.	24a. REC'D BY REGISTRAR JAN 12 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
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STATE OF TEXAS, COUNTY OF WIMBERLEY

CERTIFICATE OF DEATH



WIMBERLEY

DECEASED PERSON'S NAME

DECEASED PERSON'S AGE

DECEASED PERSON'S GENDER

DECEASED PERSON'S RACE

DECEASED PERSON'S HEIGHT

DECEASED PERSON'S WEIGHT

DECEASED PERSON'S HAIR COLOR

DECEASED PERSON'S EYE COLOR

DECEASED PERSON'S BIRTH DATE

DECEASED PERSON'S DEATH DATE

DECEASED PERSON'S PLACE OF DEATH

DECEASED PERSON'S CAUSE OF DEATH

DECEASED PERSON'S MANNER OF DEATH

DECEASED PERSON'S VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00767

756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY <i>Rural</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>184 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>1388 Tuckerman St N.W.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>washington Sanitarium + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Rebecca</i>		First	Middle	Last	4. DATE OF DEATH <i>Auerbach</i>	Month	Day	Year
5. SEX <i>female</i>		6. COLOR OR RACE <i>Jewish</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>10-28-92</i>	9. AGE (In years last birthday) <i>66 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Michael Schenkman</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude</i>				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Son - Wash. San + Hosp record</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE, COMPENSATED</i>		DUE TO <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 MONTHS</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>GENERALIZED ARTERIOSCLEROSIS WITH PARKINSONISM</i>		YEARS.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>927 Reservoir Rd</i>		20f. (City or town) <i>Glenarden</i>		(County) <i>Maryland</i> (State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>October 13, 1958</i> to <i>Jan 13, 1959</i> , that I last saw the deceased alive on <i>Jan 13, 1959</i> , and that death occurred at <i>1:26 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>927 Reservoir Rd</i>		DATE SIGNED <i>1-14-59</i>		
ACTUAL SIGNATURE <i>Allan David</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>A.W. David MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/15/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Geo. Washington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hollywood</i>		(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		ADDRESS <i>4219 9th St NW</i>		24a. REC'D BY REGISTRAR <i>Alton Sperry, M.D.</i>		24b. REGISTRAR'S SIGNATURE <i>Alton Sperry, M.D.</i>		
				DATE <i>JAN 15 '59</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00768

757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

3 mo. 4 day

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

8658 Piney Branch Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First William Joseph

Middle I

Last Baker

4. DATE
OF
DEATH

Month January

Day 30

Year 1959

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

6-28-09

9. AGE (In years
lost birthday)

49

yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Maintenance Foreman

10b. KIND OF BUSINESS OR INDUSTRY

Wash. Sub. Sanitary Com.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Edward Baker

14. MOTHER'S MAIDEN NAME

Mary Gossner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give year or dates of service)

No

None

16. SOCIAL SECURITY NO.

214-01-0323

17. INFORMANT

Hospital Record

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Colon carcinoma of Colon

INTERVAL BETWEEN
ONSET AND DEATH

11 years

100-8

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AN AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour

a. m.

19

p. m.

20d. INJURY OCCURRED

While
at work Not while
at work 20e. PLACE OF INJURY (Name, form,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from January 19, 1956, to January 30, 1959, that I last saw the deceased
alive on January 30, 1959, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Boris Rabkin

M.D. 1019 University Boulevard Silver Spring 1/30/59

PHYSICIAN'S
NAME (Type)

Boris RABKIN

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

Feb. 21/59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

Westgate Nat'l Cem.

22d. LOCATION (City, town, county)

Gaithersburg, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

W.W. Chambers Co.

Avalon, Md.

ADDRESS

24a. REC'D BY REGISTRAR

FEB 3 '59

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause



178

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00769

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

803

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If died in hospital, give street address)

DAPHINE

13301 Silver Spring st.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Earl Jefferson Baldwin

3. SEX

6. COLOR OR RACE

MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

7. DATE OF BIRTH

7-4-16

9. AGE (In years
last birthday)

42 yrs

10. IF UNDER 1 YEAR

Months Days Hours Min

11. IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Alfred Baldwin

14. MOTHER'S MAIDEN NAME

Ruth

Husband

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

YES

WW # 2

16. SOCIAL SECURITY NO.

17. INFORMANT

225-10-6596

Ruth Baldwin (wife)

Item 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

776X

DUE TO

Thoracic hemorrhage

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Shot gun wound in left chest (heart)

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Self inflicted shot gun wound

20c. TIME OF INJURY Month, Day, Year
Hour p.m.

20d. INJURY OCCURRED
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office, dog, etc.)

20f. (City or town) (County) (State)

Home Silver Spring, MD

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

FRANK J. Broschart

ASSISTANT MEDICAL EXAMINER

22a. BURIAL CREMATION, DATE THEREOF
REMOVAL (Specify)

BURIAL

1/9/59

22c. NAME OF CEMETERY OR CREMATORY

ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county)

ARLINGTON, VIRGINIA

DATE SIGNED

Jan 5-59

23. FUNERAL DIRECTOR'S SIGNATURE

WALTER E. PUMPHREY, INC.

Raymond A. Barker

ADDRESS

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

JAN 7 '59

24b. REGISTRAR'S SIGNATURE

John J. Nease

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS. A15ME
SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00770

804

CERTIFICATE OF DEATH

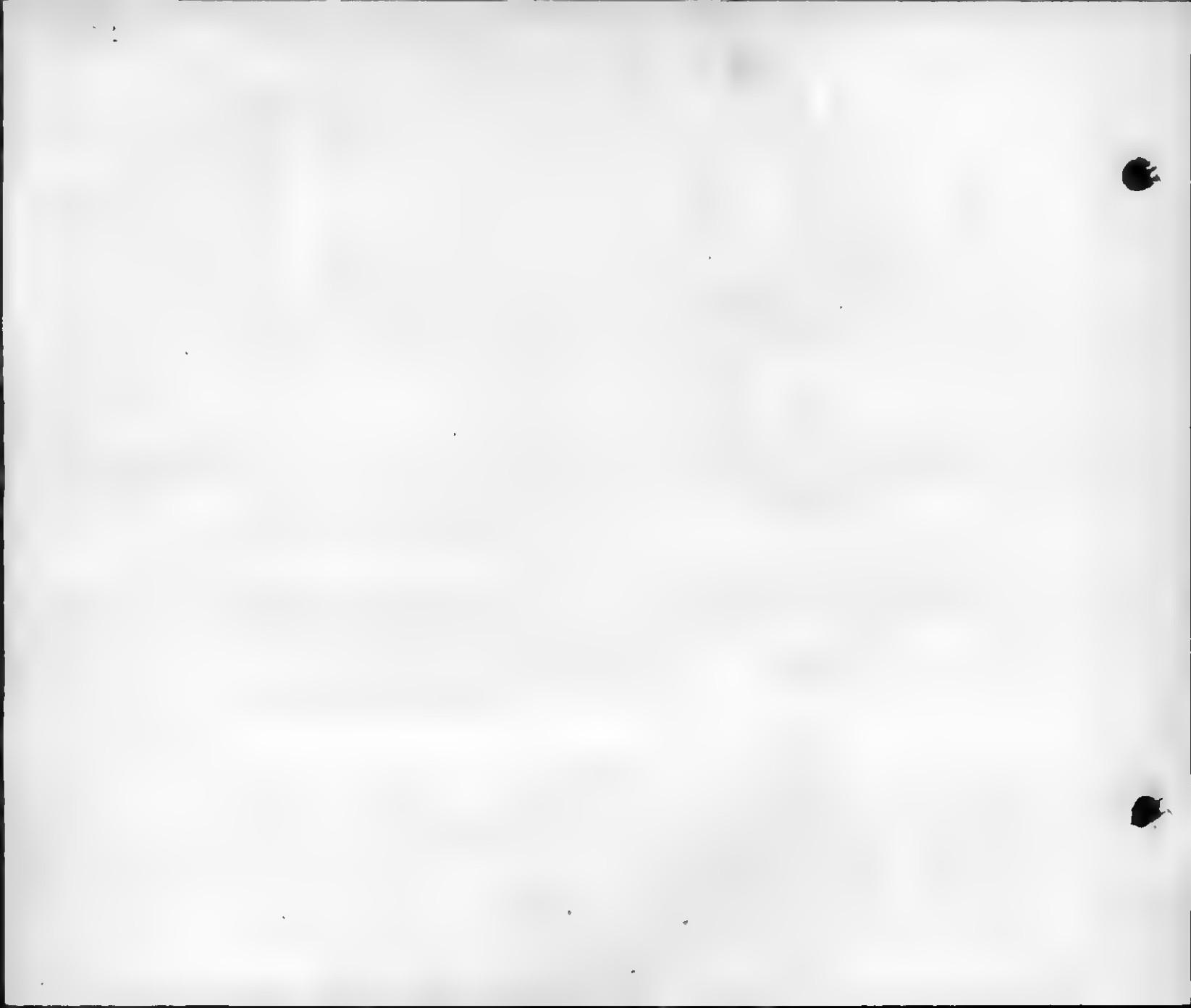
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		d. LENGTH OF STAY IN 1b 11 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		e. LENGTH OF STAY IN 2b 15005 ARGYLE CLUB Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		SEYMOUR NURSING HOME		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
F		WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	JUL. 13, 1868	9. AGE (In years last birthday) 90 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		Homemaker		TRENTON, N.J.	
12. CITIZEN OF WHAT COUNTRY?		C.I.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John C. Tabram		Emma Whittall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
NO				Mrs. Joseph G. Blandi, 6411 Highland St. Cincinnati	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CERERAL THROMOSIS		INTERVAL BETWEEN ONSET AND DEATH 5 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		GENERALIZED ARTERIOSCLEROSIS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
19				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 20, 1959, to Jan 25, 1959, that I last saw the deceased alive on Jan 23, 1959, and that death occurred at 4 AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		918 UNIV. BLVD. E.		DATE SIGNED 1/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		Jan. 28, 1959		Colonial Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE	
J. Arthur Walters		254 Carroll St. NW DC		24b. REGISTRAR'S SIGNATURE C. L. Knudsen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

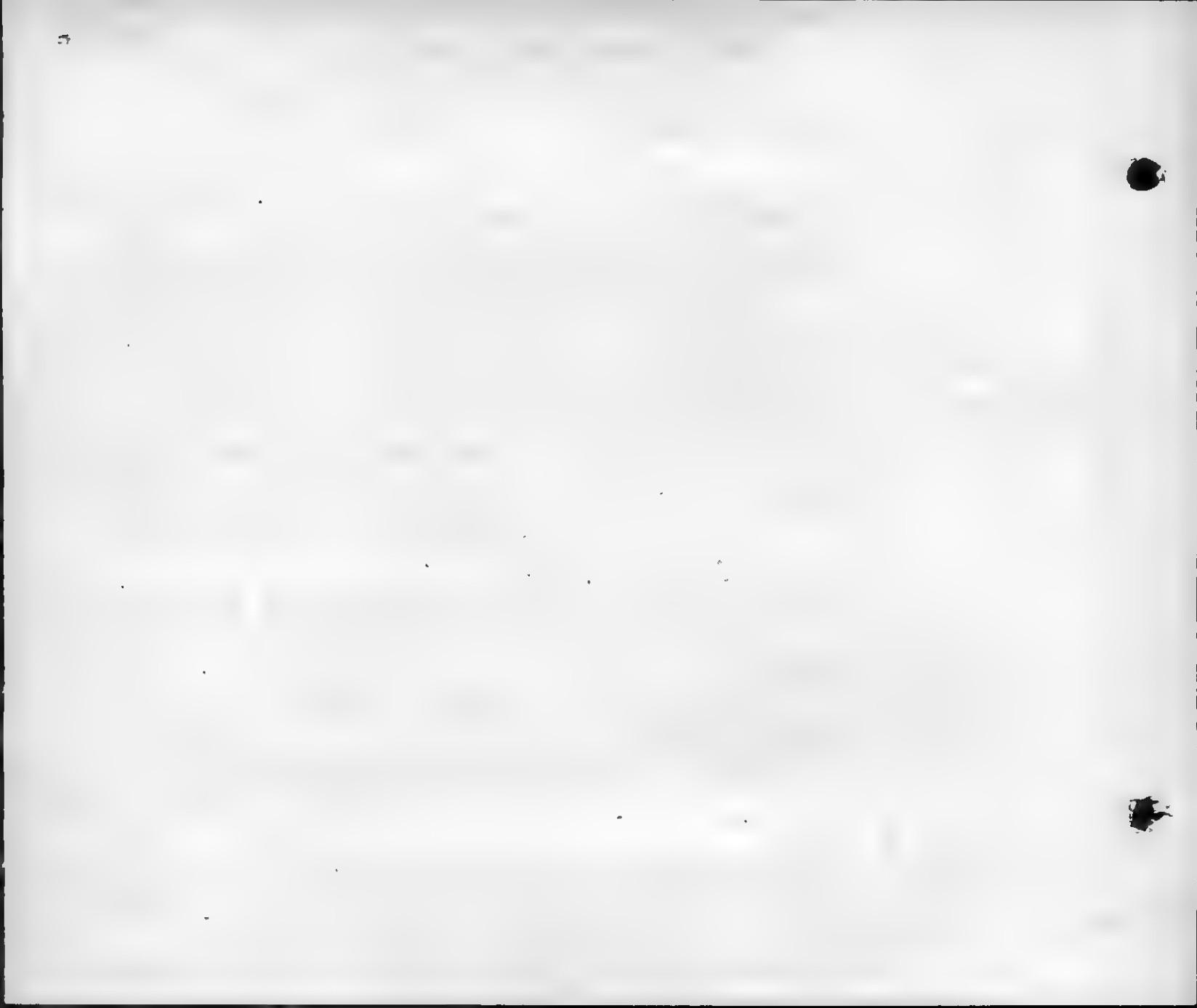
1. PLACE OF DEATH a. COUNTY		805		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No.		
Montgomery						a. STATE Md		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		2 days				Grantville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4701 Adrian St		d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year		
Eva May Beachy					Jan	6	1959			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DAY OF BIRTH	9. AGE (In years last birthday)	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HR Hours Min
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-8-1879 79 yrs.	Housewife		Maryland	A. S. A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT	Address		
Gilead Broadwater		Ada Maust		(If yes, give war or dates of service)			James C. Beachy (son)	Item 1 sudden		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary occlusion		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 5 yrs		
		420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.		Suffocation						
		(c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
19										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Frank J. Blaschke		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 6 1959				
EXAMINER'S NAME (Type)		FRANK J. Blaschke								
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, Town, or county)		(State)		
Burial		Jan. 9, 1959		Grantville		Grantville, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
Lee Funeral Home - Washington D.C.										
VS A15ME		DATE JAN 9 '59								
BM 2 57										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 806 CERTIFICATE OF DEATH										00772			
										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kensington, Md.		c LENGTH OF STAY IN lb		a. STATE		b. COUNTY					
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Kensington Gardens Sant.				WASH.		D. C.					
3. NAME OF DECEASED (Type or print)		First Elmer	Middle L.	Last Beales	4. DATE OF DEATH	Month JAN.	Day 4	Year 1959	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 75 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOORMAN-COL. THEATRE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
DAVID HENRY BEALES		ANNA REBECCA Thompson		(If yes, give war or date of service)		578-40-6100 REBECCA LA FUERNE (DAUGHTER)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastases and										6 months			
DUE TO (c) Cancer of Prostate										4 mos + 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I attended the deceased from <u>Jan. 4</u> , 1959, to <u>Jan 4</u> , 1959, that I last saw the deceased alive on <u>Jan. 3</u> , 1959, and that death occurred at <u>8:41</u> A.M., from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>R Stephen Hulbert</i>		M.D.		<u>5000 Rockville Place, N.W., Washington, D.C.</u>									
PHYSICIAN'S NAME (Type) <i>R Stephen Hulbert, M.D.</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/59		22c. NAME OF CEMETERY OR CREMATORIUM Lakeview Cemetery		22d. LOCATION (City, town, or county) Hamilton		(State) Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Leeason</i>		ADDRESS West. L. C.		24a. REC'D BY REGISTRAR DATE JAN 6 '59		24b. REGISTRAR'S SIGNATURE <i>J. W. Leeason</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00778

807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Montgomery County</i> MARYLAND		Wash. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i>		<i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>Alt. Vista Conv. Home 9200 E 10th Street, Gaithersburg, Md.</i>	<i>4104 Harrison St NW</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
<i>Sarah C. Beaver</i>			Jan. 30 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Jan 9, 1883</i>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Retired</i>		<i>School Teacher Pa.</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Joseph Lepley</i>		<i>Florence Ellett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		<i>North L. Beaver, 4104 Harrison St NW</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral Hemorrhage</i>	
<i>55x</i>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Cerebral Arteriosclerosis</i>	
(b)		DUE TO	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 7</i> , 1957, to <i>Jan 30</i> , 1959, that I last saw the deceased alive on <i>Jan 29</i> , 1959, and that death occurred at <i>10:30</i> P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>5516 Nebraska Avenue DC</i> DATE SIGNED <i>1-30-59</i>	
ACTUAL SIGNATURE <i>Robert B. Howell</i>		M.D. <i>Robert B. Howell</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>2/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Kratzerville Cem.</i>		<i>Kratzerville Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE FEB 4 '59	
<i>Cherry Chase Funeral Home</i>		24b. REGISTRAR'S SIGNATURE <i>L. Wm. S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

758 CERTIFICATE OF DEATH

00774

Reg. Dist. No.

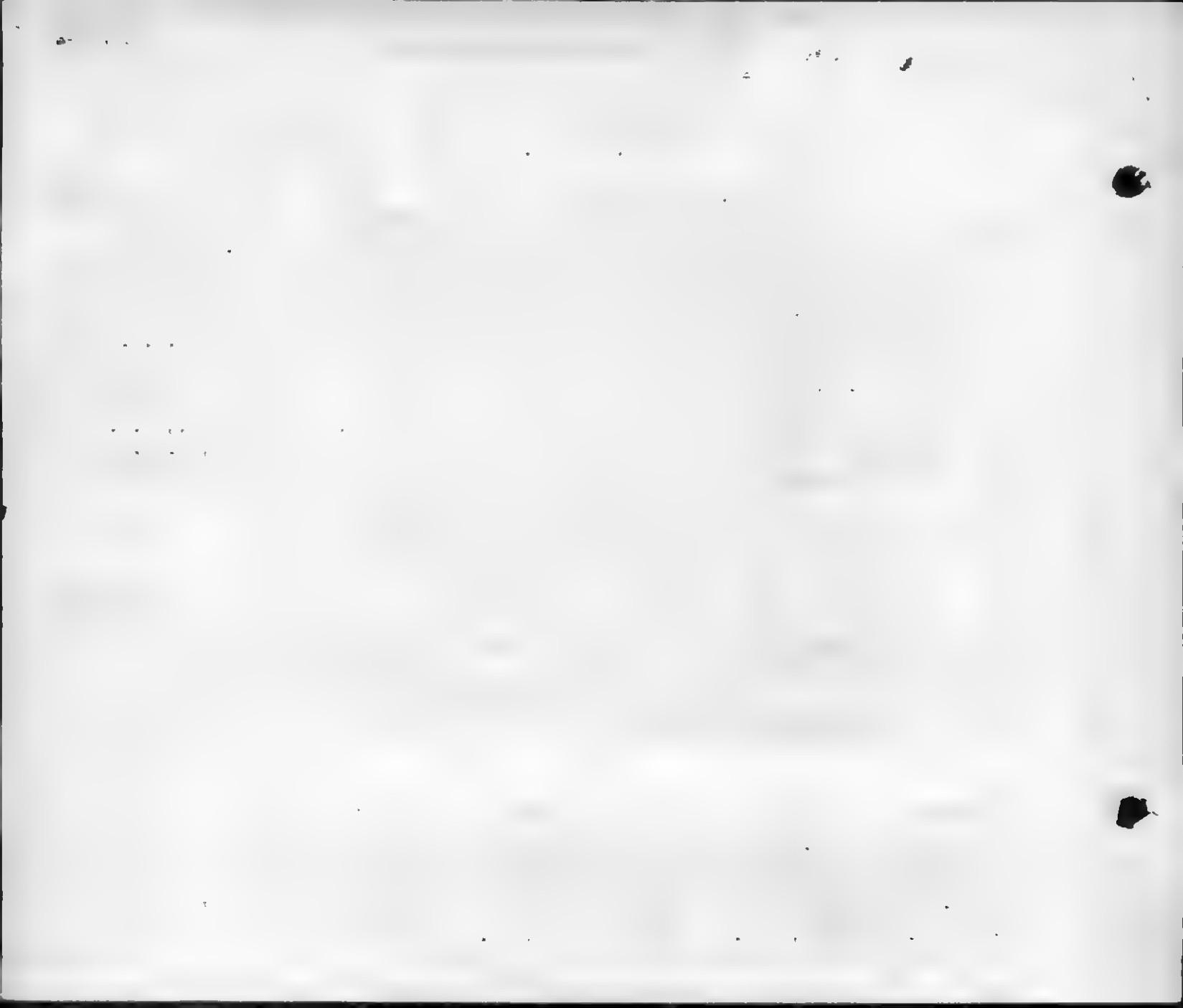
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b Approx. 12 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) First MARY Middle HUNEKE Last BEERS		4. DATE OF DEATH Month JAN. Day 26 Year 19 59	
5. SEX FEMALE COLOR OR RACE WHITE		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH 10/10/07		8. AGE (In years last birthday) 51 yrs.	
9. IF UNDER 1 YEAR Months Days Hours Min.		10. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) COLORADO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES J. HUNEKE		14. MOTHER'S MAIDEN NAME MARY THOMPSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown, NO)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Miss Cecelia Huneke, 1301 15th St., N.W. Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 10 hours.	
DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hyper tension, systemic (c)		Cerebral hemorrhage (massive) Chikungunya	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 24, 1956, to Jan 26, 1959, that I last saw the deceased alive on Jan 26, 1959, and that death occurred at 5:00 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE AARON H. TRAUM M.D. 8237 Georgia Ave. Silver Spring, Md., 127-19 PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 1/31/59		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN CEMETERY	
22d. LOCATION (City, town, or county) COLORADO SPRINGS, COLORADO		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zucka.		24a. ADDRESS SILVER SPRING, MD.	
		24b. REC'D BY REGISTRAR JAN 28 '59	
		24b. REGISTRAR'S SIGNATURE Aaron H. Traum	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by

page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the register prior to burial. Removal, reburial, removal, on an event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00775

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

798			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission)	
Montgomery Rockville		b. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville		Rockville	
c. LENGTH OF STAY IN 1b		STREET ADDRESS	
6 weeks		1710 Upper Mill Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1710 Upper Mill Rd			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Jeffrey Robert Bahanna		Jan 23 1959	
First Middle Last		Month Day Year	
5. SEX Male		5. COLOR OR RACE <u>White</u>	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-16-58</u>		9. AGE (In years last birthday) <u>yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clyde Bahanna</u>		14. MOTHER'S MAIDEN NAME <u>Rita Stofko</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> Address		16. SOCIAL SECURITY NO. <u>None</u>	
(Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Clyde Bahanna -</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		475X Asphyxia	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		Upper Respiratory Infection	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>1-23-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHART</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF <u>1/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>JAN 28 '59</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

808

CERTIFICATE OF DEATH

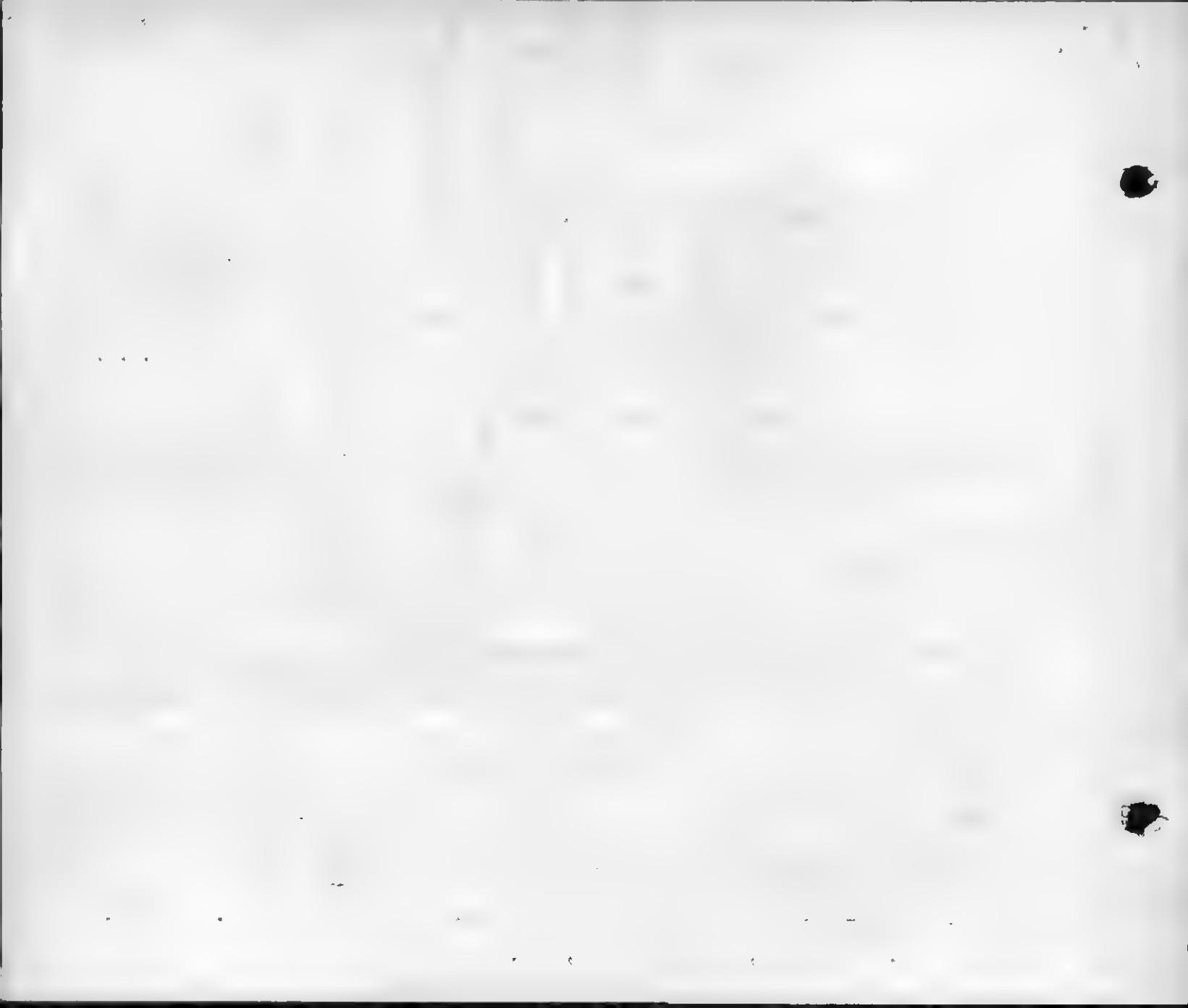
00776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Pennsylvania</u>		b. COUNTY <u>Cambria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nettleton</u>		d. STREET ADDRESS <u>Box 11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Ronald</u>	Middle <u>Joseph</u>	Last <u>Behory</u>	4. DATE OF DEATH	Month <u>January</u>	Day <u>23</u>	Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1950</u>	9. AGE (In years lost birthday) <u>8 yrs</u>	IF UNDER 1 YEAR <u>10 Months</u>	IF UNDER 24 HRS. <u>13 Days</u>	Hours <u>0 Hours</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Behory</u>				14. MOTHER'S MAIDEN NAME <u>Doris Gore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Meningitis and Septicemia</u> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Epidermolysis Bullosum</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 5, 1958</u> , to <u>January 23, 1959</u> , that I last saw the deceased alive on <u>January 23, 1959</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>Arthur T. Teplitzky</u> M.D. <u>1-23-59</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Arthur T. Teplitzky</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Pike Brethren Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambria Co., Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00777

309

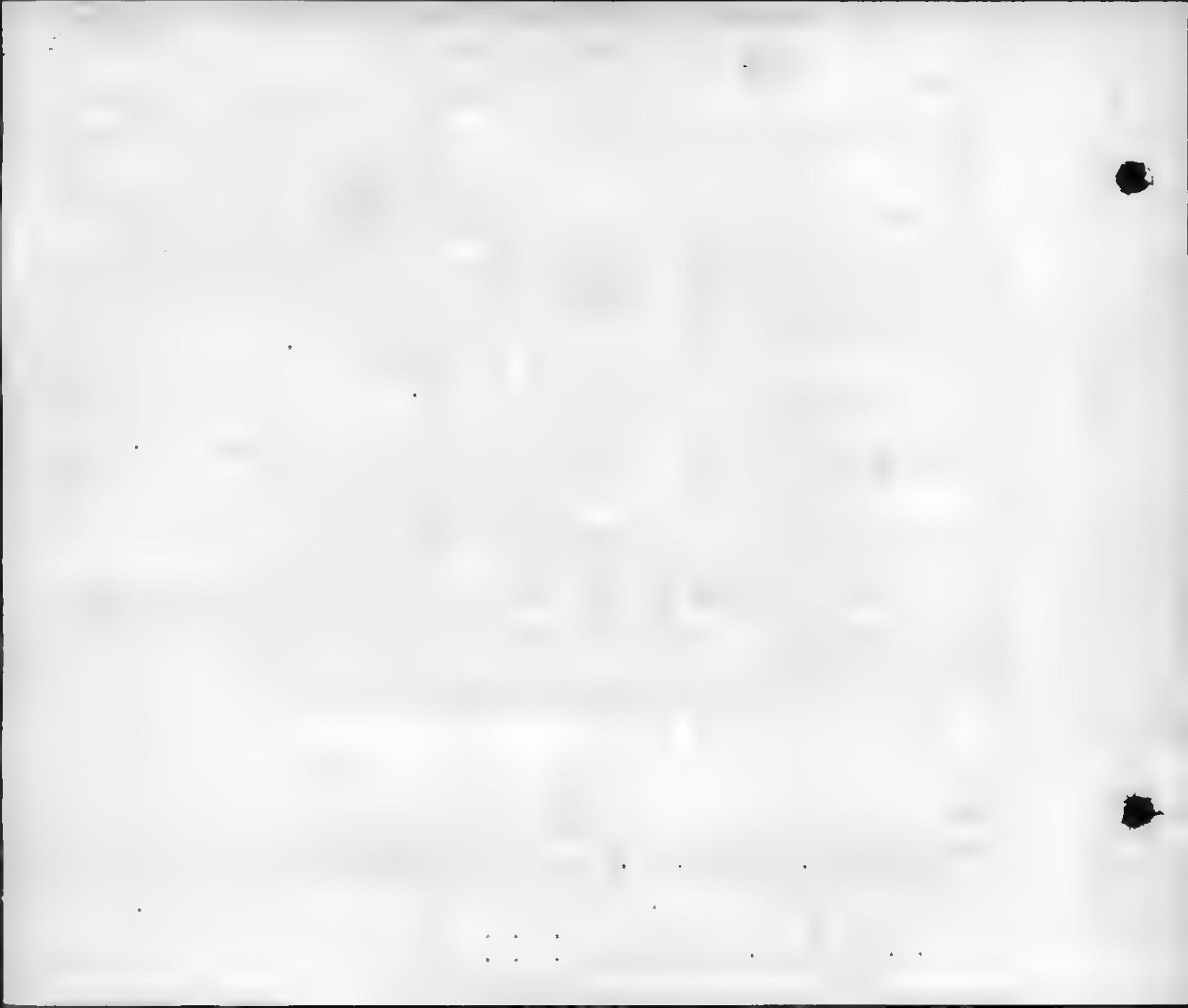
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5402 Lambeth Road		e. STREET ADDRESS 5402 Lambeth Road	
3. NAME OF DECEASED (Type or print) Mary Jane Montgomery Birgfeld		4. DATE OF DEATH January 27, 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/80
9. AGE (In years lost birthday) 78 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? 5116 Westridge Rd. Westhaven, Md.	
13. FATHER'S NAME Charles Montgomery		14. MOTHER'S MAIDEN NAME Alice M. Cole	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO Kenneth Birgfeld	
17. INFORMANT 5116 Westridge Rd. Westhaven, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Respiratory Failure Cerebral Thrombosis Cardio vascular - renal Disease			
INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 weeks 6 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 5707 Wisconsin Ave (County) Chevy Chase 15, Md. (State)	
21. I certify that I attended the deceased from 8/28 , 19 58 , to 1/27 , 19 59 , that I last saw the deceased alive on 1/21 , 19 59 , and that death occurred at 9:50 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank J. Jaggers Jr.</i> M.D. ADDRESS (Street, city or town, state) 5707 Wisconsin Ave Chevy Chase 15, Md. DATE SIGNED 1/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/59	
22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) Prince George, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR JAN 28 '59	24b. REGISTRAR'S SIGNATURE S. Turner
24c. ADDRESS 2901 14th St. N.W.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director,
page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

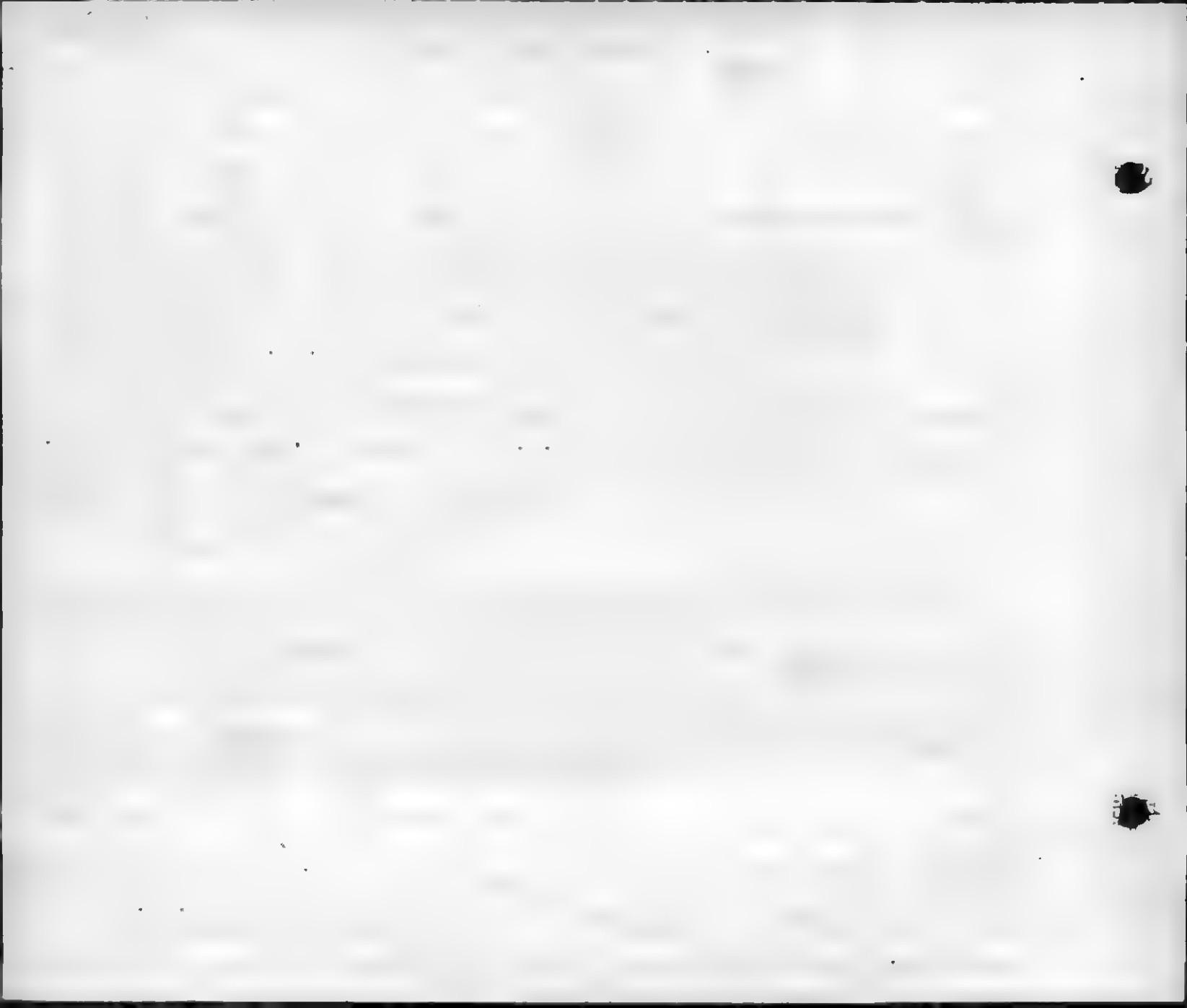
00778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		810 MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 32 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3719 Bradley Lane				d. STREET ADDRESS 3719 Bradley Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SAHA		First V	Middle BLACKISTONE	Last BLACKISTONE	4. DATE OF DEATH January 28	Month January	Day 28	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1874		9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR OR IF UNDER 24 HRS Months 5 Days 13 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Edmond Gaines Wheeler				14. MOTHER'S MAIDEN NAME Sarah Murray				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Z.D. Blackistone, Jr.-Son-Bethesda, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Cerebro-vascular thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour p. m. 19	Month 19	Day Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rock Creek Cemetery	20f. (City or town) Washington, D. C.	(County)	(State)	
21. I certify that I attended the deceased from April , 1955, to Jan 28 , 1959, that I last saw the deceased alive on Jan 27 , 1959, and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Paul Delantor M.D. 4109 Montgomery - Rock Creek Cemetery DATE SIGNED Jan 28, 1959								
ACTUAL SIGNATURE Paul Delantor								
PHYSICIAN'S NAME (Type) Robert A. Pumphrey								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/59	22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 2 '59		24b. REGISTRAR'S SIGNATURE John J. Keane		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00780

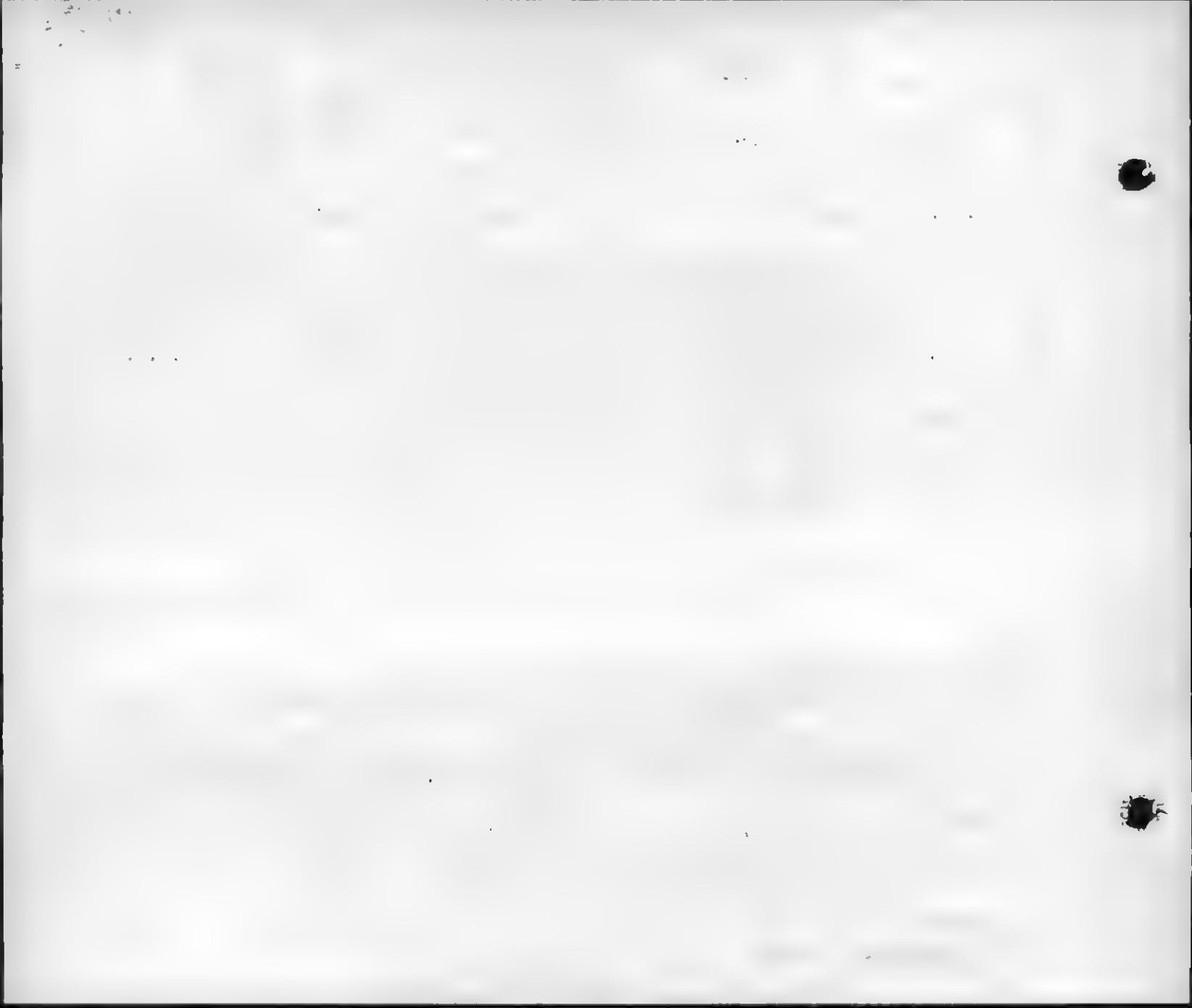
812

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE District of Columbia		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1925 Belmonte Street					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph		First	Middle Daniel	Last BLUNDELL	4. DATE OF DEATH January 19	Month	Day	Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-99	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph BLUNDELL		14. MOTHER'S MAIDEN NAME Elizabeth JARMAN		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WWII 579-42-8457		17. INFORMANT Official Navy Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Bronchogenic carcinoma with metastases				INTERVAL BETWEEN ONSET AND DEATH approx 6 months					
		Terminal diffuse bronchopneumonia				approx 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from December 15, 1958 , to January 19, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above											
ACTUAL SIGNATURE						ADDRESS (Street, city or town, state)		DATE SIGNED 1-19-59			
PHYSICIAN'S NAME (Type)		Jerome A. GOLD, LT, MC, USN		M.D.		U. S. Naval Hospital					
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS IVER'S FURNITURE HOME, 2847 Wilson Blvd., Arlington		Va.		24a. REC'D BY REGISTRAR DATE JAN 22 59		24b. REGISTRAR'S SIGNATURE J. S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

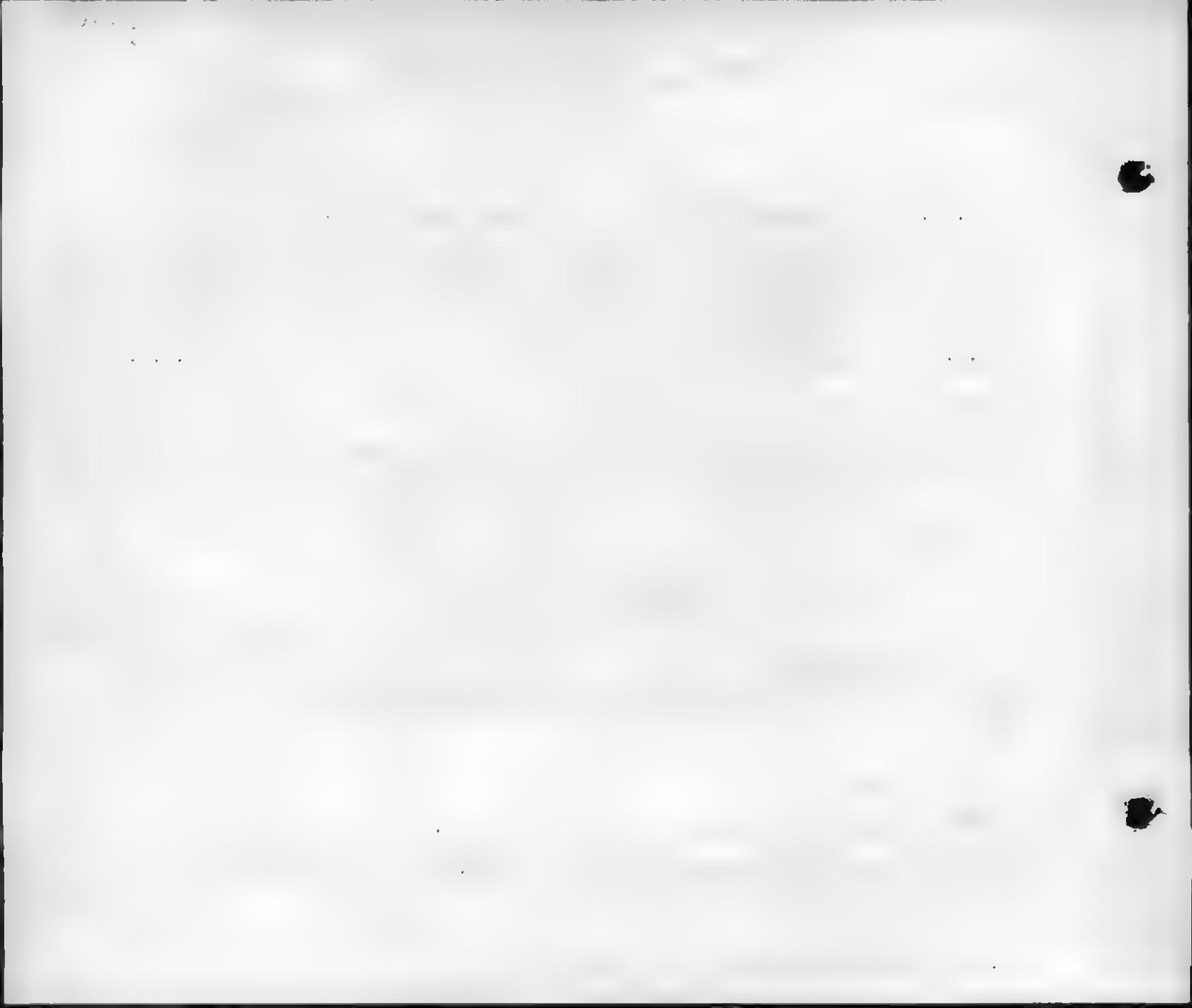
00781

813

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 60 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 5077 Bradley Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Samuel		First James	Middle BONNER	Losl January 19	4. DATE OF DEATH January 19 1959	Month January	Day 19	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-99	9. AGE (In years last birthday) 59	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Frederick BONNER		14. MOTHER'S MAIDEN NAME Fannie BARNES						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO. [If yes, give war or dates of service] WWII		17. INFORMANT Mrs. Margaret Bonner (W), same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute pulmonary edema				INTERVAL BETWEEN ONSET AND DEATH 14 hours		
430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Aortic insufficiency				3 weeks		
		(c) Arteriosclerotic heart disease				Indef.		
		(d) Subacute bacterial endocarditis				3 months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19		20d. INJURY OCCURRED While or work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 20, 1958 , to January 19, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC						DATE SIGNED 1-20-59		
ACTUAL SIGNATURE <i>J. T. Horgan</i>		M.D.						
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 22 1959		24b. REGISTRAR'S SIGNATURE <i>E. J. Flanagan</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

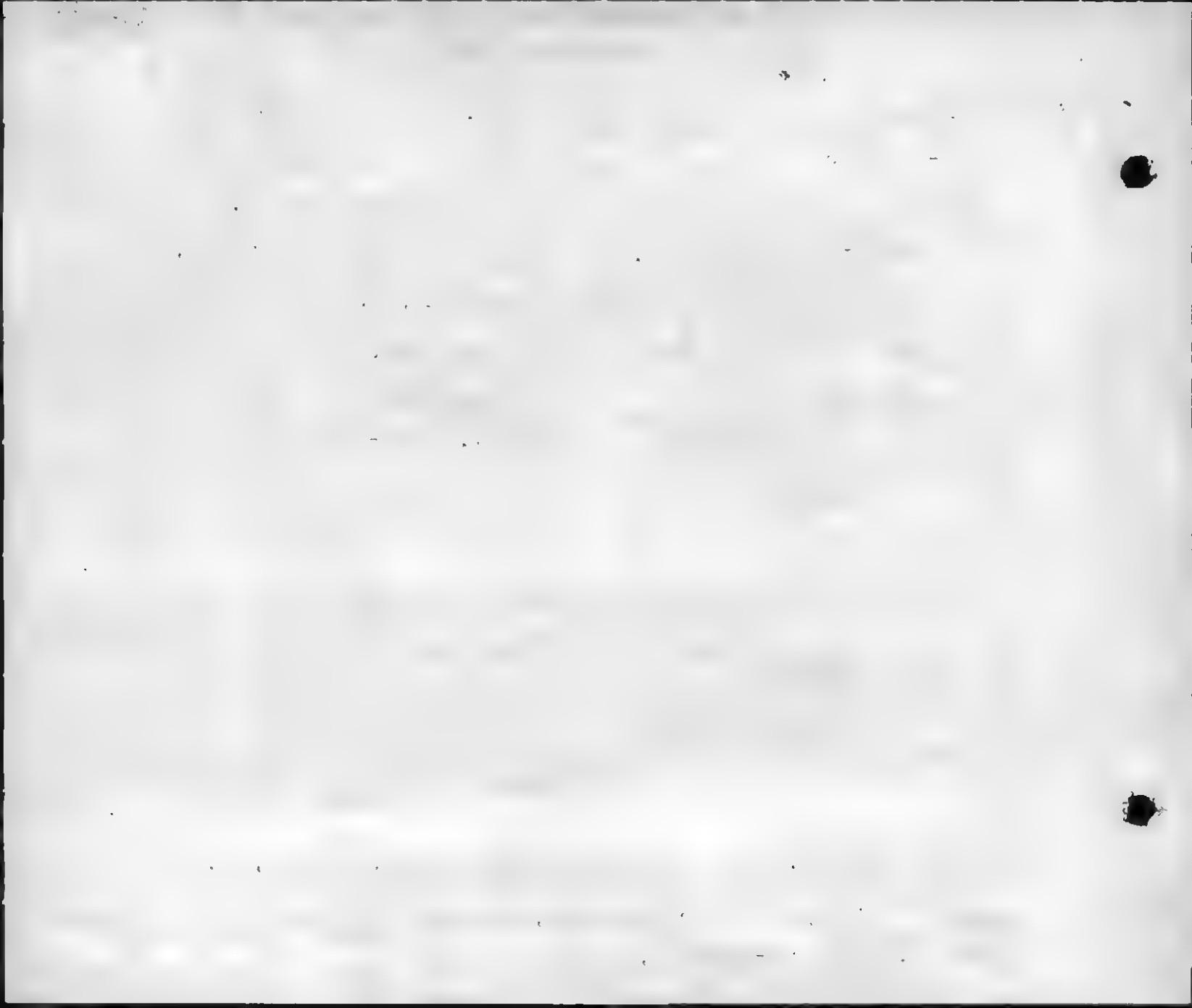
00782

814

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) Ropine Rest Home		d. STREET ADDRESS 10501 Old Georgetown Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Laura	Middle B.	Last Bortz	4. DATE OF DEATH January 10,	Month Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1877	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 11 Days 21 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Philip Markley		14. MOTHER'S MAIDEN NAME Hettie Bossert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Nelson M. Bortz-Item # 2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Failure - INTERVAL BETWEEN ONSET AND DEATH 36 hr.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) Cerebral Thrombosis & convulsions - 36 hr.			
DUE TO (c)		Arterio Sclerosis Generalized 20 yr-			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1921, to date - 1959, that I last saw the deceased alive on 10 Jan 1959, and that death occurred at 4:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John G. Ball M.D. 1/10/59					
PHYSICIAN'S NAME (Type) John G. Ball 7936 Old Georgetown Road, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORIUM Schwenksville Cemetery		22d. LOCATION (City, town, or county) (State) Schwenksville, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland			ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 14 59	24b. REGISTRAR'S SIGNATURE John G. Ball



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00783

815

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) a. STATE Illinois		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 158 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 7115 South Yates Street		e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles Vernon Bowles		First	Middle	Last	4. DATE OF DEATH January 16, 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 18, 1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY (Unknown)		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME William A. Bowles		14. MOTHER'S MAIDEN NAME Mary L. Jones							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 335-01-7313		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mycosis Fungoides		DUE TO (b) Massive Pulmonary Involvement		INTERVAL BETWEEN ONSET AND DEATH Years		Weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Chronic Lung Disease-Bronchiectasis & Emphysema		DUE TO (c) Chronic Lung Disease-Bronchiectasis & Emphysema							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. January 16, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center		20f. (City or town) Indianapolis		(County) Indiana	(State) Indiana
21. I certify that I attended the deceased from August 11, 1958 , to January 16, 1959 , that I last saw the deceased alive on January 16, 1959 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul Schwab, M.D.</i>				ADDRESS (Street, city or town, state) National Institutes of Health		DATE SIGNED 1-16-59			
PHYSICIAN'S NAME (Type) Paul Schwab, M. D.									
22a. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Transit-Burial 1-17-59		22c. NAME OF CEMETERY OR CREMATORIUM Washington Park Cem.		22d. LOCATION (City, town, or county) Indianapolis, Indiana		(State) Indiana			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE <i>J. S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00784

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

500 Blk. Park Pl.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

500 Blk. Park Pl.

3. NAME OF
DECEASED
(Type or print)

ELMER

First

Middle

H

BRIENT

5. SEX

Male

White

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

Lost

4. DATE
OF
DEATH

January

13

19 59

8. DATE OF BIRTH

Jan 29, 1892

9. AGE (In years
to birthday)

66 yrs

10. IF UNDER 1 YEAR

Mo. 11 Yrs

IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Theater

10b. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Brient

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Theodore C Brient-son-as item 2d

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

420.1
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1-13-59

EXAMINER'S
NAME (Type)

Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/16/59

22c. NAME OF CEMETERY OR CREMATORIUM

Parklawn Cemetery

22d. LOCATION (City, town, or county)

Rockville, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

Bethesda, Maryland

24a. REC'D. BY REGISTRAR

1/16/59

24b. REGISTRAR'S SIGNATURE

Arnold S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00785

817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Bethesda</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>D.C. H.</i>		c LENGTH OF STAY IN 1b <i>4 weeks</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>4531 Millerton Lane</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Silverman</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Rogers Eugene Briggs</i>		First	Middle	Last	4. DATE OF DEATH <i>January 3 1959</i>	Month	Day	Year
5. SEX <i>M</i>		6. COLOR OF HAIR <i>Blk</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Oct 4 1885</i>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> c. AGE (In years last birthday) <i>73 yrs.</i>	9. IF UNDER 1 YEAR <i>2 months</i>	10. IF UNDER 24 HRS <i>2 days</i>	11. IF UNDER 1 MONTH <i>2 hours</i>	12. IF UNDER 24 HRS <i>Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery store attendant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery store</i>		11. BIRTHPLACE (State or foreign country) <i>Newark, N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Yes</i>		
13. FATHER'S NAME <i>Morris Eugene Briggs</i>		14. MOTHER'S MAIDEN NAME <i>Jane Rodgers</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>577-10-6652-A</i>		17. INFORMANT <i>Arlene Briggs, wife, 4531 Millerton Lane</i>		Address <i>Dept. 18 M.L.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		Myocardial Infarction.		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <i>(c)</i>				Arteriosclerotic Heart Disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>June 24, 1958, 19 58</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 1506-17th St N.W.</i>		20f. (City or town) <i>Suitland, Maryland</i>		(County) (State)
21. I certify that I attended the deceased from <i>June 24, 1958, to Jan 26, 1959</i> , that I last saw the deceased alive on <i>Dec 26, 1958</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>John Hernandez</i>		ADDRESS (Street, City or town, state) <i>1506-17th St N.W.</i>		DATE SIGNED <i>1-3-59.</i>				
PHYSICIAN'S NAME (Type) <i>JOHN. HERNANDEZ</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1/5/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Suitland, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Jan 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. K. 14</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



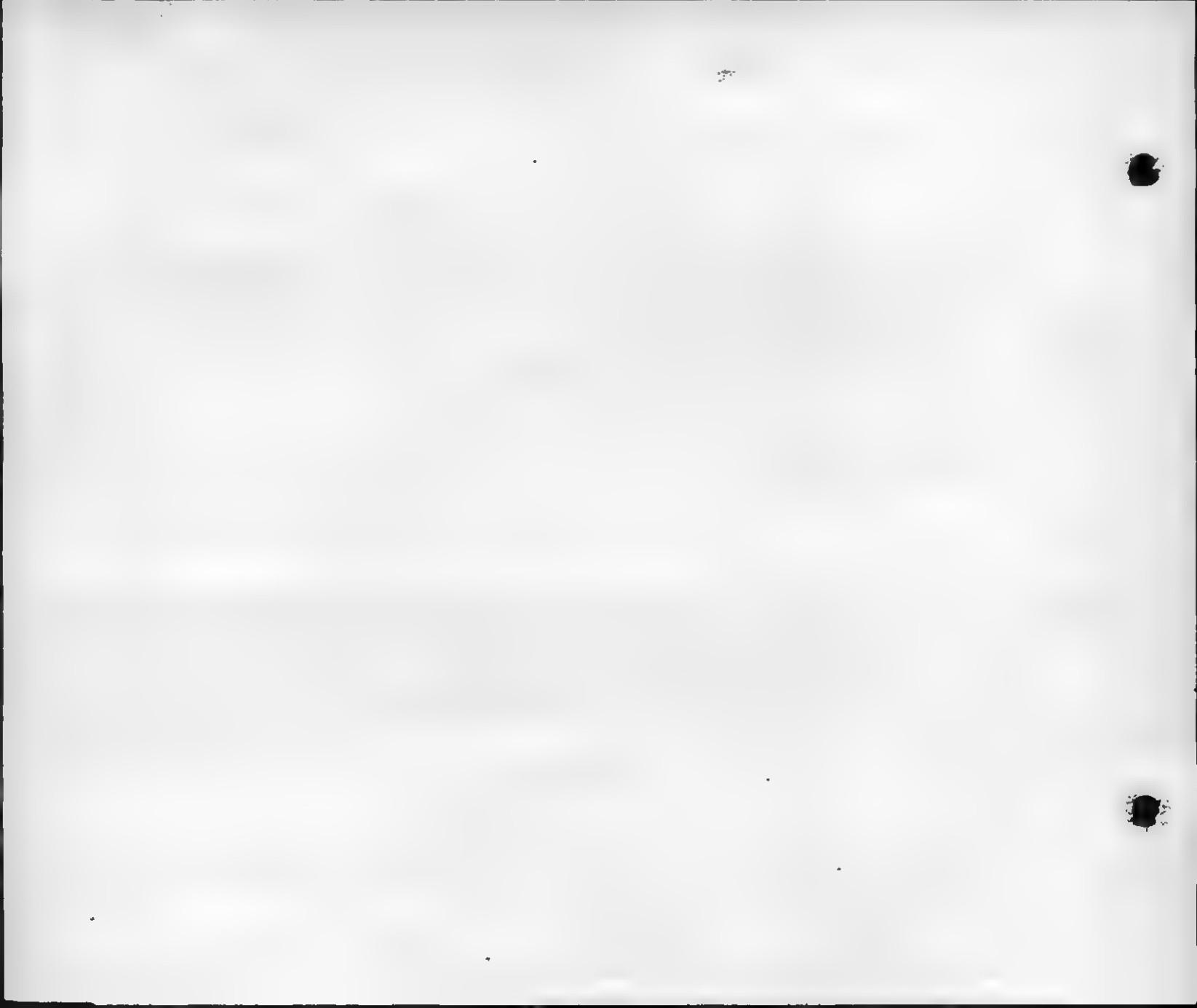
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00786

818 CERTIFICATE OF DEATH

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 14 hrs. 40 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kirklyn	
73		d. STREET ADDRESS 131 Cunningham Lane	
3. NAME OF DECEASED (Type or print) Sarah		First Middle Emma	4. DATE OF DEATH Brooks January 15 19 59
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 6, 1882		9. AGE (In years lost birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin Riley		14. MOTHER'S MAIDEN NAME Sarah Ambler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO NO	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Congestive heart failure Coronary insufficiency		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intestinal obstruction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1951 to Jan 1952, that I last saw the deceased alive on Jan 1952, and that death occurred at 1:40 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE L. I. Leal		M.D.	
PHYSICIAN'S NAME (Type)		Gaithersburg, Maryland 1.15.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan, 19	
22c. NAME OF CEMETERY OR CREMATORIUM \$100.00 Holy Cross		22d. LOCATION (City, town, or county) Lansdowne (State) Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber		ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE JAN 19 '59
		24b. REGISTRAR'S SIGNATURE Collier & Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00787

819

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
b. STATE

Maryland

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL and give nearest town)

c. LENGTH OF STAY IN 16

RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

e. IS RESIDENCE ON A FARM?

YES NO

F. First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

G. M

H. Burroughes

I. 5. SEX

J. COLOR OR RACE

K. MARRIED NEVER MARRIED L. WIDOWED DIVORCED

M. 6. DATE OF BIRTH

N. AGE (in years lost birthday)

O. IF UNDER 1 YEAR

P. Months

Q. Boys

R. Hours

S. Min

T. Female

U. White

V. Widowed

W. Divorced

X. July 24, 1877

Y. 81 yrs

Z. 6

AA. 8

BB. 1959

CC. 30

DD. 12. CITIZEN OF WHAT COUNTRY:

EE. Housewife

FF. Own Home

GG. Washington D. C

HH. US

II. 13. FATHER'S NAME

JJ. Unknown

KK. 14. MOTHER'S MAIDEN NAME

LL. Unknown

MM. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NN. If yes, give war or date of service)

OO. 16. SOCIAL SECURITY NO.

PP. None

QQ. 17. INFORMANT

RR. Mrs. Eastwood-daughter-same x as 2d

SS. Address

TT. No

UU. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

VV. PART I. DEATH WAS CAUSED BY:

WW. IMMEDIATE CAUSE (a)

XX. 420.1 DUE TO

YY. Conditions if any, which

ZZ. gave rise to immediate

AA. cause (a), stating the under-

BB. lying cause last

CC. DUE TO

DD. (b) Hypertensive arteriosclerotic heart disease 20 yrs

EE. (c) CORONARY INFARCTION 24 hours

FF. (d) 24 hours

GG. (e) 24 hours

HH. (f) 24 hours

II. (g) 24 hours

JJ. (h) 24 hours

NN. (i) 24 hours

OO. (j) 24 hours

PP. (k) 24 hours

QQ. (l) 24 hours

RR. (m) 24 hours

TT. (n) 24 hours

UU. (o) 24 hours

VV. (p) 24 hours

WW. (q) 24 hours

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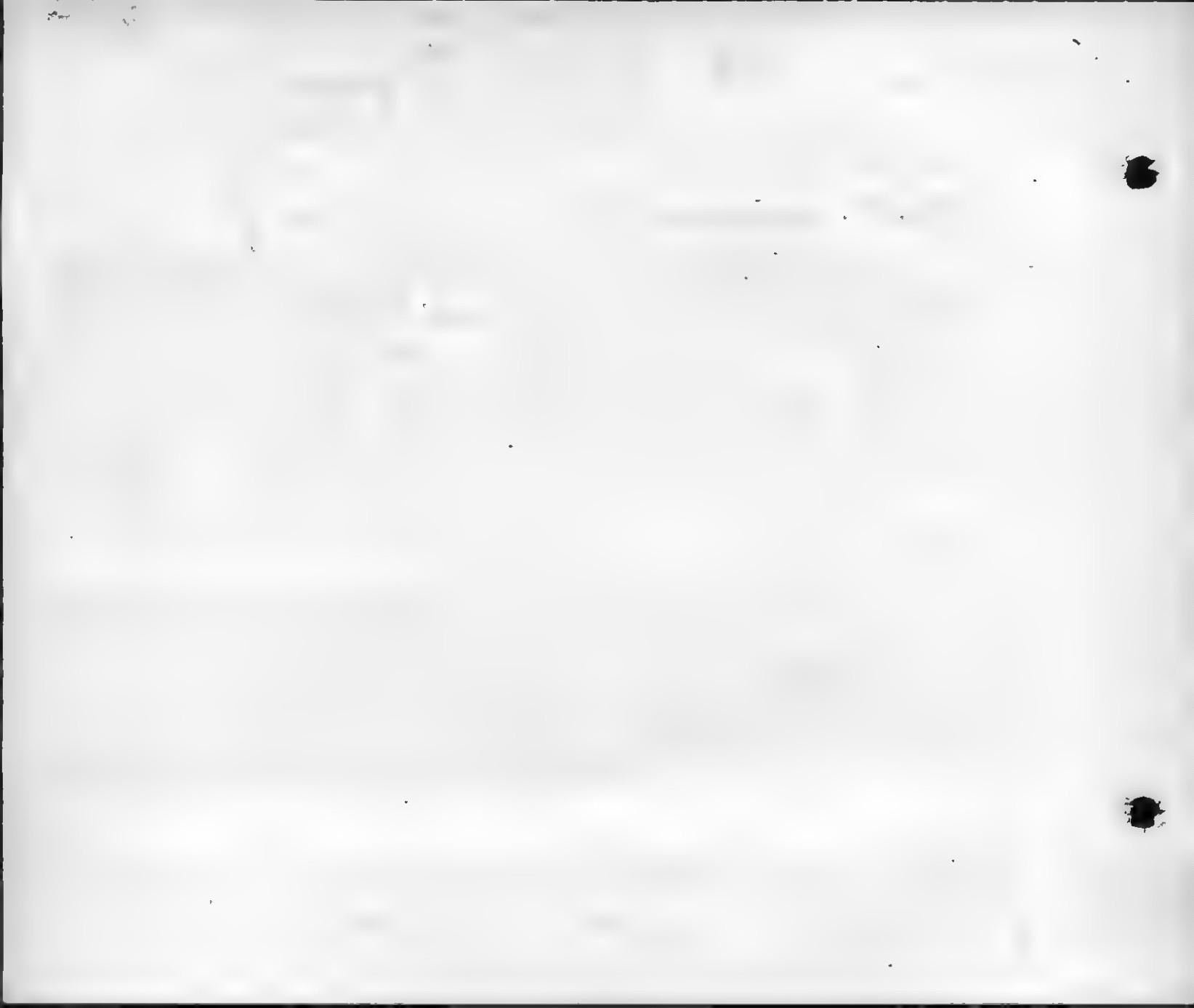
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JJ. (hh) 24 hours

OO. (ii) 24 hours

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QQ. (kk) 24 hours



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00788

820

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Tennessee b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 33 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nashville ✓ 79X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 924 North Fifth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lannie	Middle Leo	Last Buterbaugh
4. DATE OF DEATH	Month January	Day 9	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 3, 1936
9. AGE (In years less birthday) 22 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Alexander Clyde Buterbaugh		14. MOTHER'S MAIDEN NAME Rose Hicks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Clotted Right Hemothorax with PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency, Anoxia and Cardiac Arrest. 6 hr. 1545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease. DUE TO Surgical Repair of Congenital Heart Disease using (c) Extracorporeal Circulation.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 7, 1958, to January 9, 1959, that I last saw the deceased alive on January 9, 1959, and that death occurred at 6:30 P.M. from the causes and on the date stated above ACTUAL SIGNATURE William P. Cornell M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/10/59 PHYSICIAN'S NAME (Type) WILLIAM P. CORNELL, M.D. ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Nashville (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. 1400 Chapin St. N.W.		24a. REC'D BY REGISTRAR DATE JAN 13 '59	
		24b. REGISTRAR'S SIGNATURE C. J. S. Kaud	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00789

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN 1b	b. COUNTY	
Olney	9 days	Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Montgomery County General Hospital, Inc.	Gaithersburg Route #3		
3 NAME OF DECEASED (Type or print)	First Clytis Middle	Last Butt	4 DATE OF DEATH
	#111475 Lena		January 19 1959
5. SEX	6 COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 1, 1923
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
35 yrs.	Housewife	West Virginia	U. S. A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Edward Graham	Flossie Collins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	UNKNOWN	Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATOSIS</i> INTERVAL BETWEEN ONSET AND DEATH <i>Not known</i>			
115.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adeno carcinoma left ovary</i> (c) <i>Not known</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 30, 1958, to Jan 18, 1959, that I last saw the deceased alive on Jan 18, 1959, and that death occurred at 12:40AM, from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Jack Schumacher</i>		ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED <i>Jan 19, 1959</i>	
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.		Gaithersburg, Maryland	
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-21-59	22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak Cemetery	22d LOCATION (City, town, or county) (State) Gaithersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber Laytonsville, Md.	ADDRESS	24a. REC'D BY REGISTRAR JAN 23 59	24b. REGISTRAR'S SIGNATURE <i>John S. Moore</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00790

822

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>7204 Exfair Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i>		Middle <i>Joseph</i>		4. DATE OF DEATH <i>Caldwell</i>		Month <i>January</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 24, 1905</i>	
9. AGE (In years lost birthday) <i>53 yrs</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Salesman</i>		11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Caldwell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Agnes Gibson</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Helen Caldwell</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>		DUE TO <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						<i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3101 Coopers Ave. N.E.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>3101 Coopers Ave. N.E.</i>		DATE SIGNED <i>1-18-59</i>	
ACTUAL SIGNATURE <i>Roger Litz</i>							
PHYSICIAN'S NAME (Type) <i>Roger Litz</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 21, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven Cem.</i>		22d. LOCATION (City, town, or county) <i>Silver Spring, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>JAN 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 238 1-25-59 ame

00791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson Park</i>		c. LENGTH OF STAY IN 1b <i>45 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>City 24</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <i>Benjamin Franklin Calhoun</i> (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Year <i>1 - 8 1959</i>	Month	Day
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-15-88</i>	9. AGE (In years last birthday) <i>30 yrs.</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS Days <i>23</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Jack Calhoun</i>		14. MOTHER'S MARRIED NAME <i>Sarah Frye</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>respiratory obstruction</i> DUE TO (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma floor mouth</i>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car accident</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Bernard Kiploff</i>		ADDRESS (Street, city or town, state) <i>931 Pershing Dr. Silver Spring, Md.</i>		DATE SIGNED <i>1/8/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/10/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS <i>Robert A. Pumphrey, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>1/12/59</i>		24b. REGISTRAR'S SIGNATURE <i>in my office</i>	
VS A15 (4) 15M 10/57							



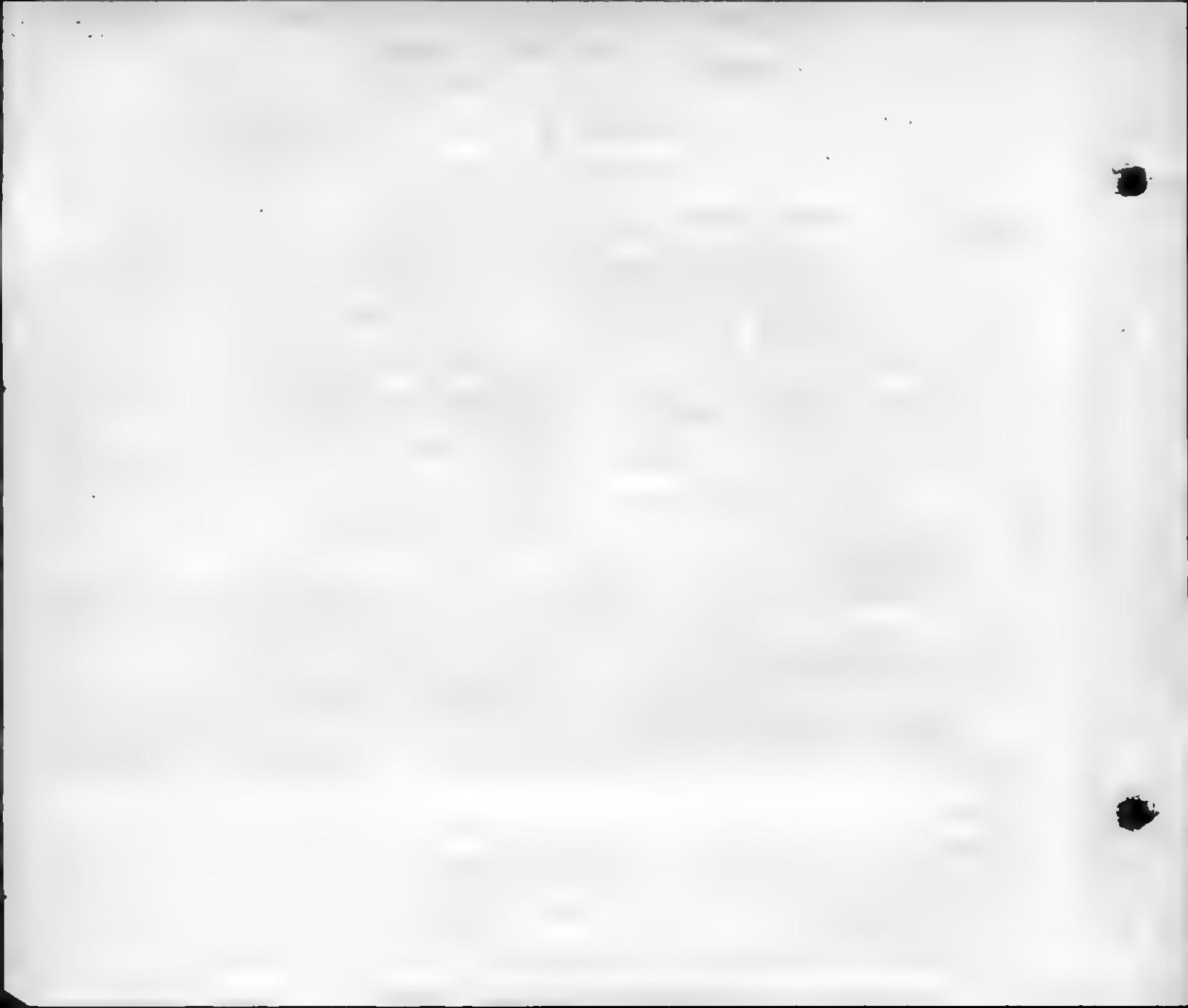
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		760 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Takoma Park		40 days		Washington D.C.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		3810 Davis Pl. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Washington-Sanitarium & Hospital								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Celia (W.W.) Caplan					1 - 3	1959		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Female White				1-22-01	7	Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Secretary—Health Ed. & Welfare—DC Mass.						America		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Isaac Caplan		Rebecca Goldman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		577-42988		Hospital Records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Seizure sarcoma of Liver		INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 1-1-57, 1957, to 1-3, 1959, that I last saw the deceased alive on 1-1-57, 1959, and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE		M.D.		BERNARD H. OSTROW		7961 EASTERN AVE. S.S. Mo.		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
Burial		1-4-59		King David Memorial		Heels Chapel, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Fielder Funeral Home 4217-9 Hillside Rd.				DATE JAN 6 1959				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film Gc58 2nd set

00793

823

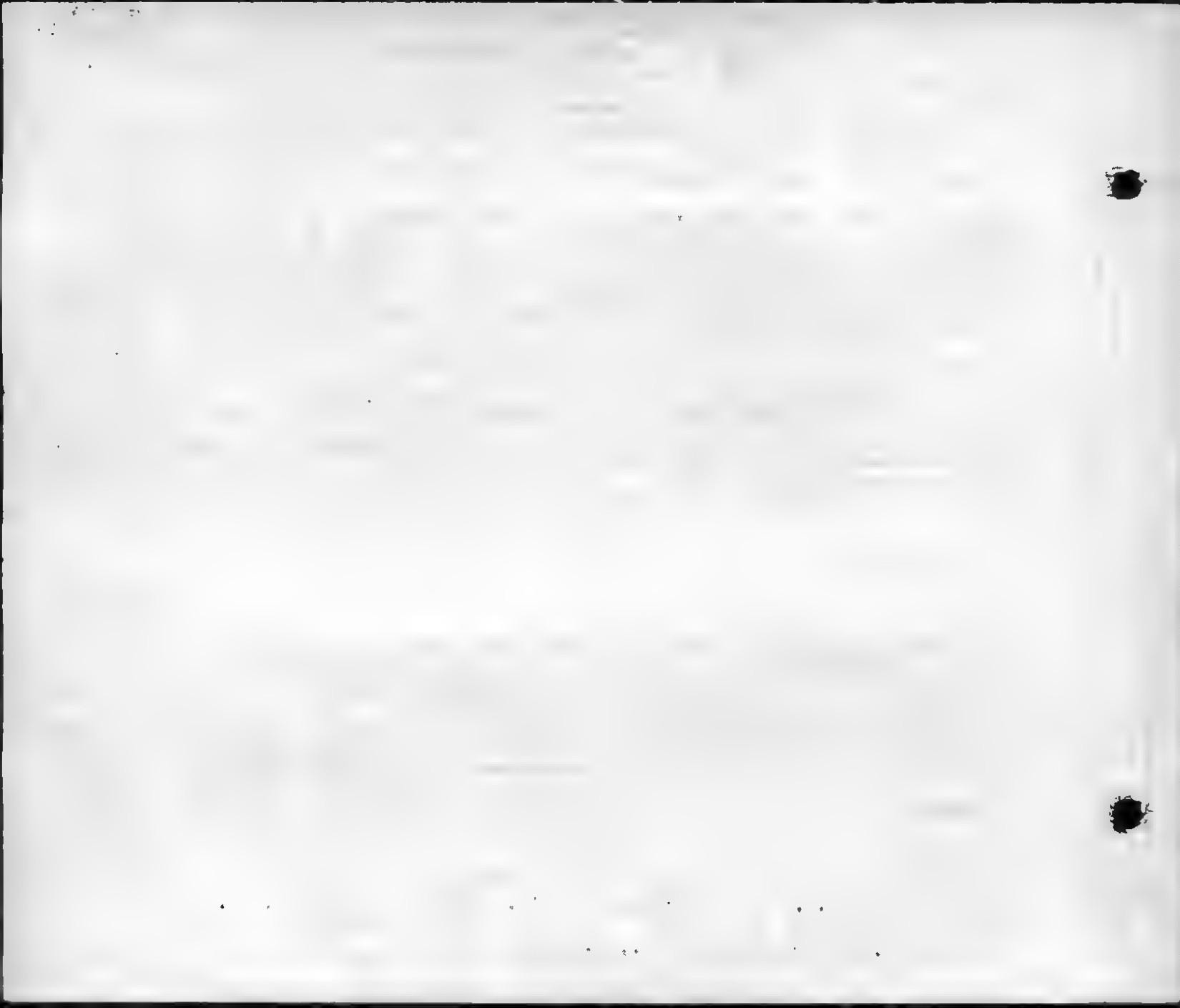
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		11. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hr - 45 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) Infant (Newborn)		First C	Middle ARROLL
4. DATE OF DEATH JAN. 28		Month JAN.	Day 28
5. SEX Female		d. COLOR OR RACE Negro	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/59
		DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) yrs. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Edward Carroll	14. MOTHER'S MAIDEN NAME Theresa L. Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT William Edward Carroll
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO 114x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Immaturity (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 28 , 1959, to Jan 28 , 1959, that I last saw the deceased alive on Jan 28 , 1959, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomas M Wilson, M.D. 8218 Wisconsin Ave BETHESDA 14, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l. Cemetery
22d. LOCATION (City, town, or county) Arlington, Va.		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire		ADDRESS 1820 9th St., N.W.	24a. REC'D BY REGISTRAR DATE JAN 30 '59
		Washington, D.C.	24b. REGISTRAR'S SIGNATURE C. J. S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



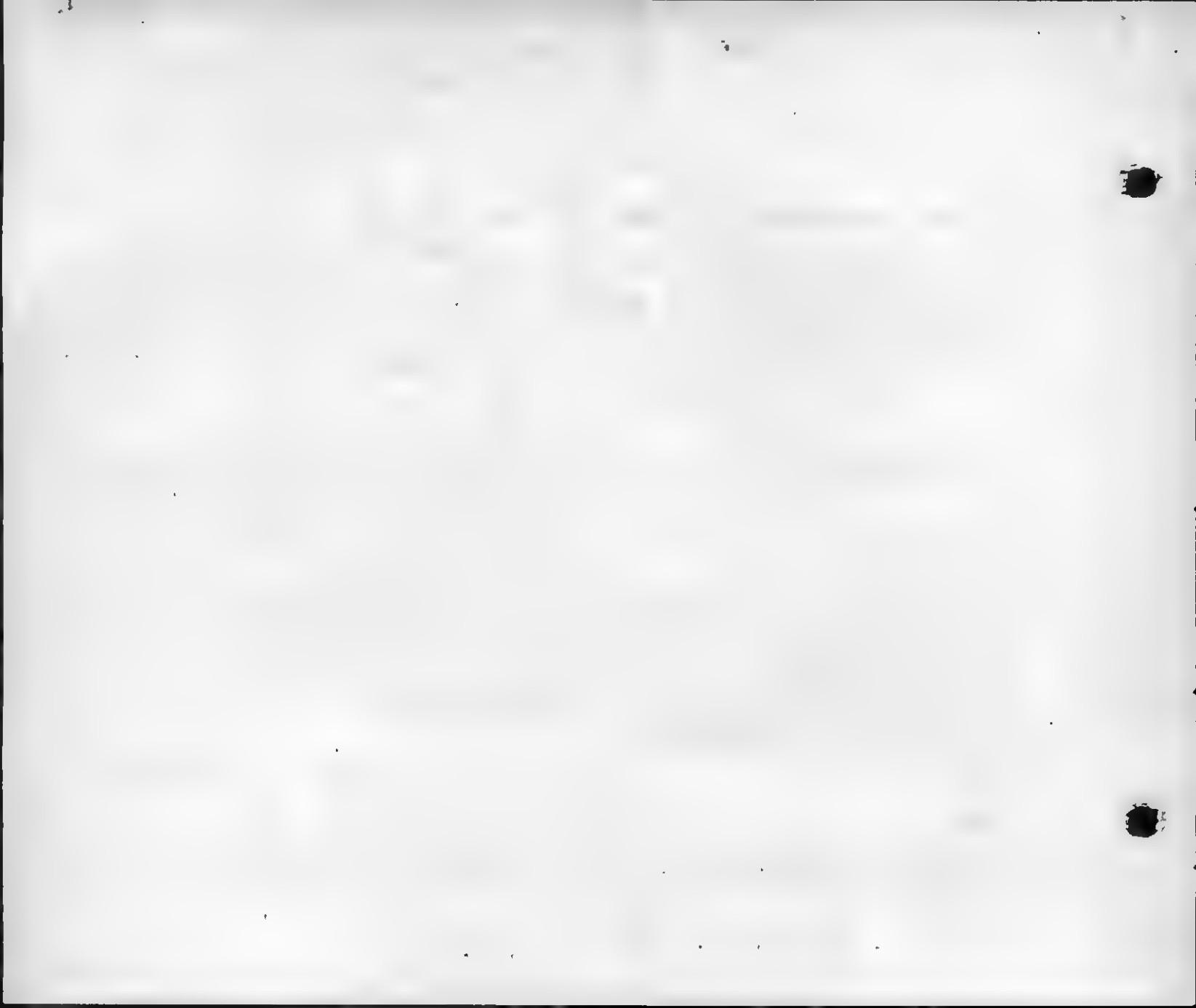
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00794

824 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if instit. or residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Viers		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/>				
f. STREET ADDRESS 908 Viers Mill Road								
3. NAME OF DECEASED (Type or print) Emily Thomas Cashell		First Emily	Middle Thomas	Last Cashell	4. DATE OF DEATH January 6 1959	Month January	Day 6	Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10.24.1890	9. AGE (In years lost birthday) 68 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Stenographer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Thomas Franklin Cashell		14. MOTHER'S MAIDEN NAME Emily Elizabeth Groomes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, unknown) <input type="checkbox"/> (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), listing the underlying cause last. (b) coronary insufficiency (c) Brachiovenenous								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 1958 , to January 6, 1959 , that I last saw the deceased alive on January 6, 1959 , and that death occurred at 2:00AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>W. A. Tinthorne</i>		M.D.		ADDRESS (Street, city or town, state) 26 W. Summit Ave., Bethesda, Md.		DATE SIGNED <i>1/6/59</i>		
PHYSICIAN'S NAME (Type) W. A. Tinthorne		M.D.		CITY Bethesda		STATE Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/9/59		22c. NAME OF CEMETERY OR CREMATORIUM ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) ROCKVILLE, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND A. ZEKA		23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND A. ZEKA		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 3 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00795

825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>Three months</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Pennsylvania</i>		b. COUNTY <i>Allegheny</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4709 Chestnut Street</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		f. STREET ADDRESS <i>Second Street</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BRIDGET</i>		First <i>F</i>	Middle <i></i>	Last <i>CANLEY</i>	4. DATE OF DEATH <i>Oct. 10, 1875</i>	Month <i>1</i>	Day <i>2</i>	Year <i>1959</i>	
5. SEX <i>F</i>		6. COLOR, OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10, 1875</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Anthony Fox</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Brane</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Irene P. Comer</i>		Address <i>4709 Chestnut St. Bethesda Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		arteriosclerosis, generalized		years.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Montgomery</i>		(County) <i>Montgomery Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert N. Coale</i>		ADDRESS <i>4630 Montgomery Ave., Bethesda Md.</i>		ADDRESS (Street, city or town, state) <i>1/2/59</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-Transit 1-5-59</i>		22b. DATE THEREOF <i>1-5-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Thomas Cemetery</i>		22d. LOCATION (City, town, or county) <i>Archbald, Penna.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>Sep. 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

761

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

LENGTH OF STAY IN TB
RURAL and give nearest town

6 years

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

217 Manor Circle

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

217 Manor Circle

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First: FLOSSIE
Middle: MAY
Last: CHRISTOPHER4. DATE
OF
DEATHMonth: January
Day: 29
Year: 1959

5. SEX

F

6. COLOR OR RACE

h.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

April 5, 1879

9. AGE (In years
from birthday)
yr.

79 yrs.

10. IF UNDER 1 YEAR

Months: 0
Days: 0

11. IF UNDER 24 HRS

Hours: 0
Min: 010a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maine

USA

13. FATHER'S NAME

Lincoln Clegg.

14. MOTHER'S MAIDEN NAME

Sarah Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes or no or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

14-10-24550

17. INFORMANT

Anne G. Edwards, 217 Manor Circle, Takoma Park, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		
443X	Pulmonary edema, Congestive failure	3 hours
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.	DUE TO (b)	Hyper tension, heart disease.
	DUE TO (c)	20 years

19. WAS AUTOPSY PERFORMED?	
YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	19. WAS AUTOPSY PERFORMED?
	Acute viral gastro-enteritis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Month: 19 Day: 19	While at work <input type="checkbox"/>		

21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
Sept. 6, 1958, to Jan. 29, 1959	M.D. 918 Blair Blvd. East, Silver Spring, Maryland	1/29/59

ACTUAL SIGNATURE	PHYSICIAN'S NAME (Type)	22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Eino Magi		Burial	Feb. 2, 1959	Riverview Cemetery	Topshtam, Maine

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE 2/2/59	24b. REGISTRAR'S SIGNATURE
John R. Lewis	184 Lincoln Avenue, Inc.		



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00797

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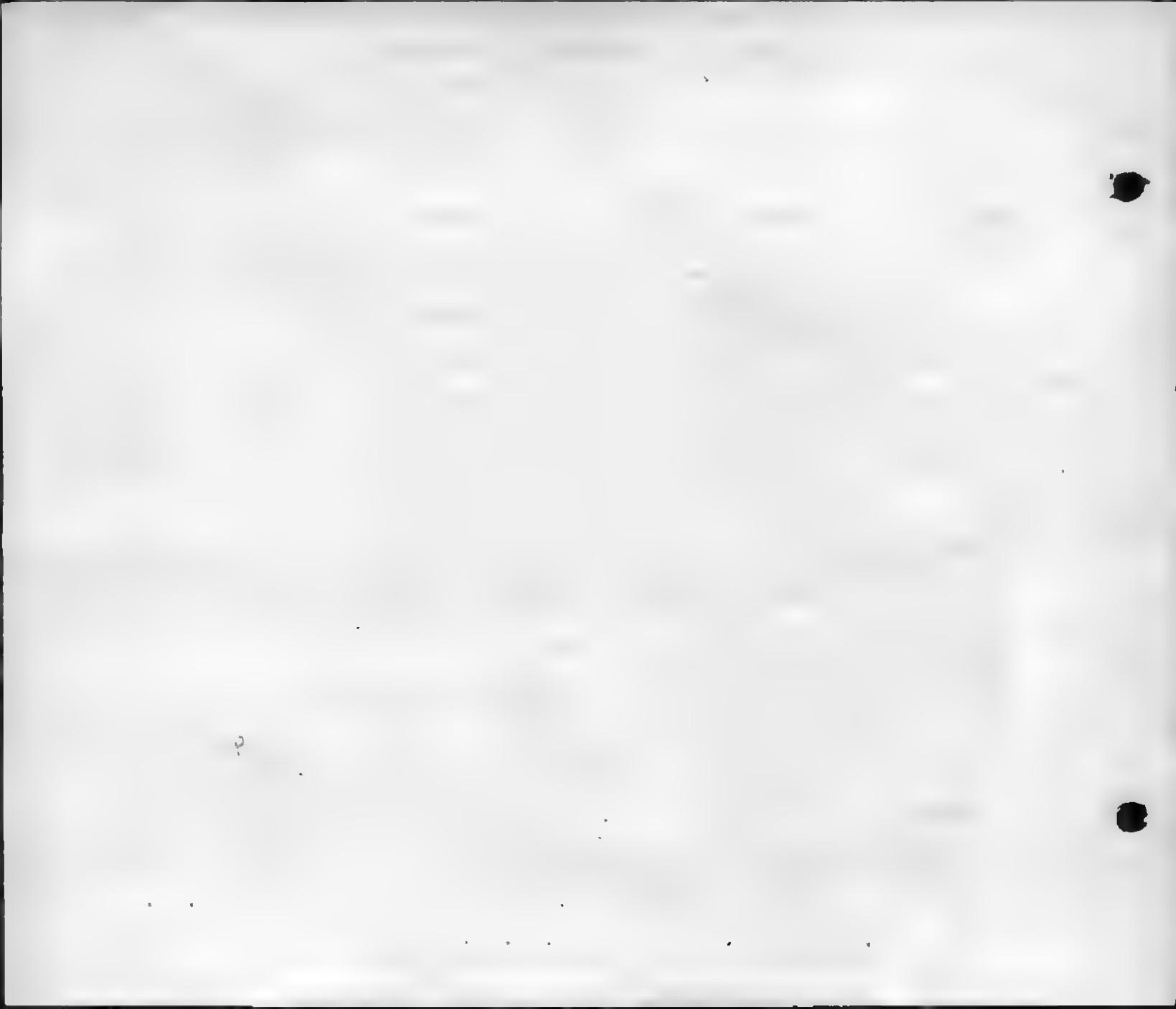
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>1731 - 15th Pl.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San & Hoop.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Vilis Gotfrids Cimermans</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan. 19 1959</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 24 1891</i>	9. AGE (In years Not birthday) <i>67 yrs.</i>	IF UNDER 1 YEAR Months <i>67</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Book Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Latvia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Latvia</i>		
13. FATHER'S NAME <i>Heinrich Cimermans</i>		14. MOTHER'S MAIDEN NAME <i>Emma Grintahl</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-48-5672</i>		17. INFORMANT <i>Richard Cimermans</i>		Address <i>7311 - 15th Pl.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>447.0 X Proxemicilia Bilateral Senility</i>		DUE TO (b) <i>Senility</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Megalolon; Congestive Heart Failure</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Washington, D. C.</i>		(County) <i>D. C.</i> (State) <i>D. C.</i>
21. I certify that I attended the deceased from <i>1-16-1959</i> to <i>1-19-1959</i> , that I last saw the deceased alive on <i>1-18-1959</i> , and that death occurred at <i>10:00 AM</i> , from the causes and on the date stated above								
ADDRESS (Street, city or town, state) <i>8829 Flower Ave, Silver Spring, Md.</i>								
DATE SIGNED <i>1-19-59</i>								
ACTUAL SIGNATURE <i>Samuel A. Hillman M.D.</i>		PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN MD</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/24/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) <i>Washington, D. C.</i> (State) <i>D. C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co.</i>		ADDRESS <i>Washington, D. C.</i>		24a. REC'D BY REGISTRAR DATE JAN 21 '59		24b. REGISTRAR'S SIGNATURE <i>Clyde S. Kraus</i>		

TO HOSPITAL may be referred by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/54



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00798

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained by the files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Reg. Dist. No.									
1. PLACE OF DEATH		825									
a. COUNTY		MONTGOMERY MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda									
c. LENGTH OF STAY IN lb		1 day									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		9501 Montgomery Dr									
e. NAME OF DECEASED (First Middle)		William Stanley Clark									
f. SEX		Male White									
g. COLOR OR RACE		Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/>									
h. WIDOWED <input type="checkbox"/>		Divorced <input type="checkbox"/>									
i. DATE OF BIRTH		9-11-02									
j. AGE (In years from birthday)		56 yrs									
k. IF UNDER 24 HRS		Months Days Hours Min.									
l. FATHER'S NAME		Emmitt R Clark									
m. MOTHER'S MAIDEN NAME		Edna Lawrence									
n. ADDRESS											
o. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		No									
p. SOCIAL SECURITY NO.		16. SOCIAL SECURITY NO.									
q. INFORMANT		Lucille Clark (wife) 1st									
r. DUE TO		Hemorrhage & Cerebral laceration									
s. DUE TO		Bullet wound thru skull (Rt temple)									
t. DUE TO		Sudden									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
u. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		v. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)									
w. TIME OF INJURY Month, Day, Year Hour e. m.		x. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		y. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		z. CITY OR TOWN		(County)		(State)	
5 p.m. 1-27 1959		While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>		Home		Bethesda		Montgomery		Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Frank J. Boscourt		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		FRANK J. Boscourt								DATE SIGNED	
220. BURIAL, CREMATION, REMOVAL (Specify)		221. DATE THEREOF		222. NAME OF CEMETERY OR CREMATORIUM		223. LOCATION (City, town, or county)				(State)	
Burial		1/30/59		Parklawn Cemetery		Rockville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		240. JAN 29 1959		246. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey		Bethesda, Maryland				Arthur & Sons					
VS. A15ME				DATE							
SM 2-57											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 1-20-59 et

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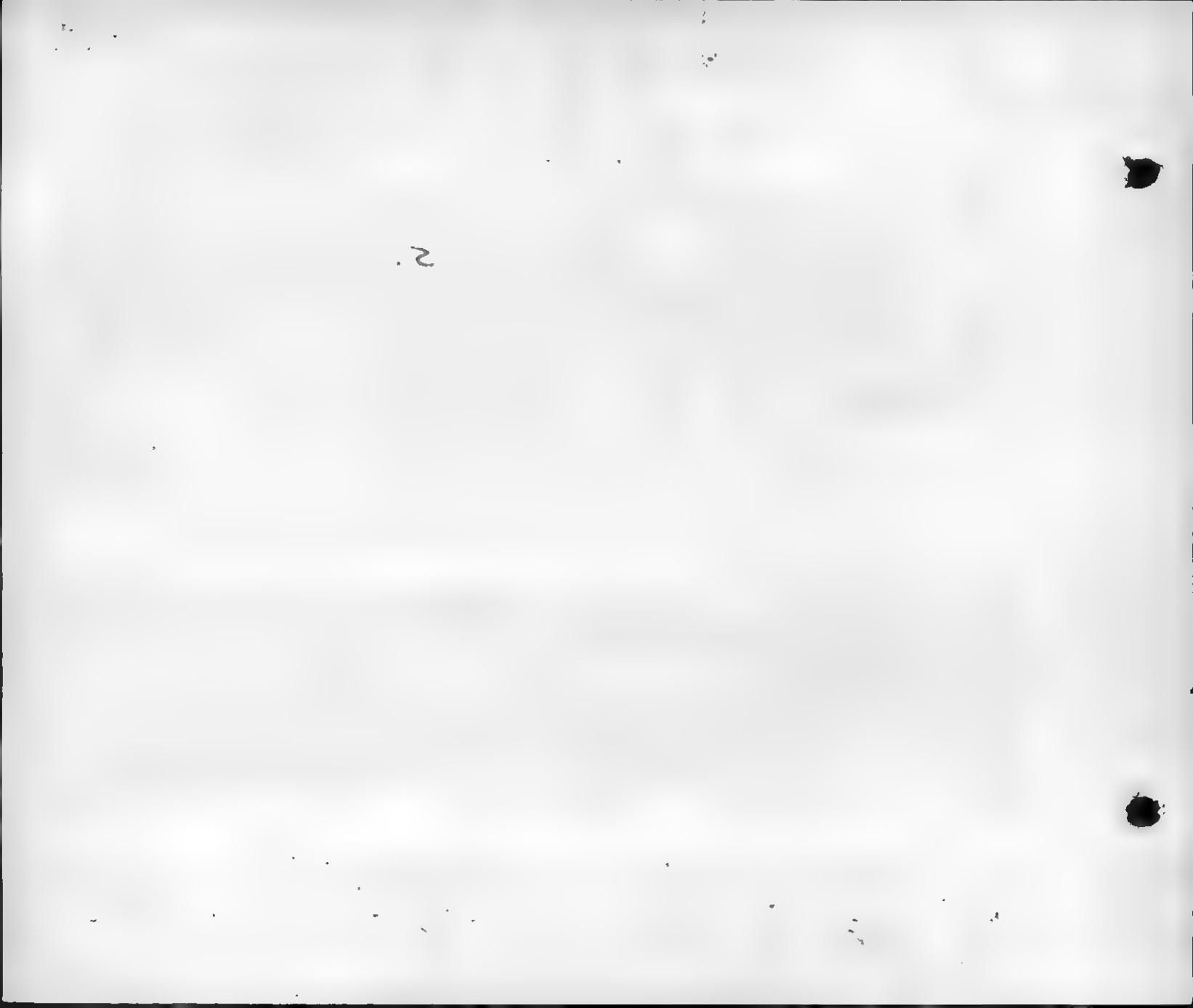
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ss on) a. STATE MARYLAND		b. COUNTY HOWARD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 DAYS. 9 HR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		d. STREET ADDRESS STAR ROUTE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES ALBERT COON, SR.		First	Middle	Last	4. DATE OF DEATH JANUARY 10 1959	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1897	9. AGE (In years lost birthday) 61 62 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FILTRATION SHIFT ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME THOMAS COON		14. MOTHER'S MAIDEN NAME MARY MARIE DISNEY				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NON		16. SOCIAL SECURITY NO.		17. INFORMANT		HOSPITAL RECORDS OLNEY, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 7 DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. / X		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) BILATERAL BRONCHOPNEUMONIA 2 DAYS				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Scaggsville, Md.		20f. (City or town) Clarksburg, Md.		(County) Clarksburg (State) Md.
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19								
21. I certify that I attended the deceased from JANUARY 4, 1959 , to JANUARY 10, 1959 , that I last saw the deceased alive on JANUARY 10, 1959 , and that death occurred at 1:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE C.S. Whitaker M.D.						ADDRESS (Street, city or town, state) Clarksburg, Md.		DATE SIGNED 1-11-59
PHYSICIAN'S NAME (Type) C.S. WHITAKER, M.D.		CLARKSVILLE, MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Emmanuel Cemetery		22d. LOCATION (City, town, or county) Scaggsville, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Randolph, Laurel, Md.		ADDRESS Laurel, Md.		24a. REG'D BY REGISTRAR John T. 6 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinney		
				DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

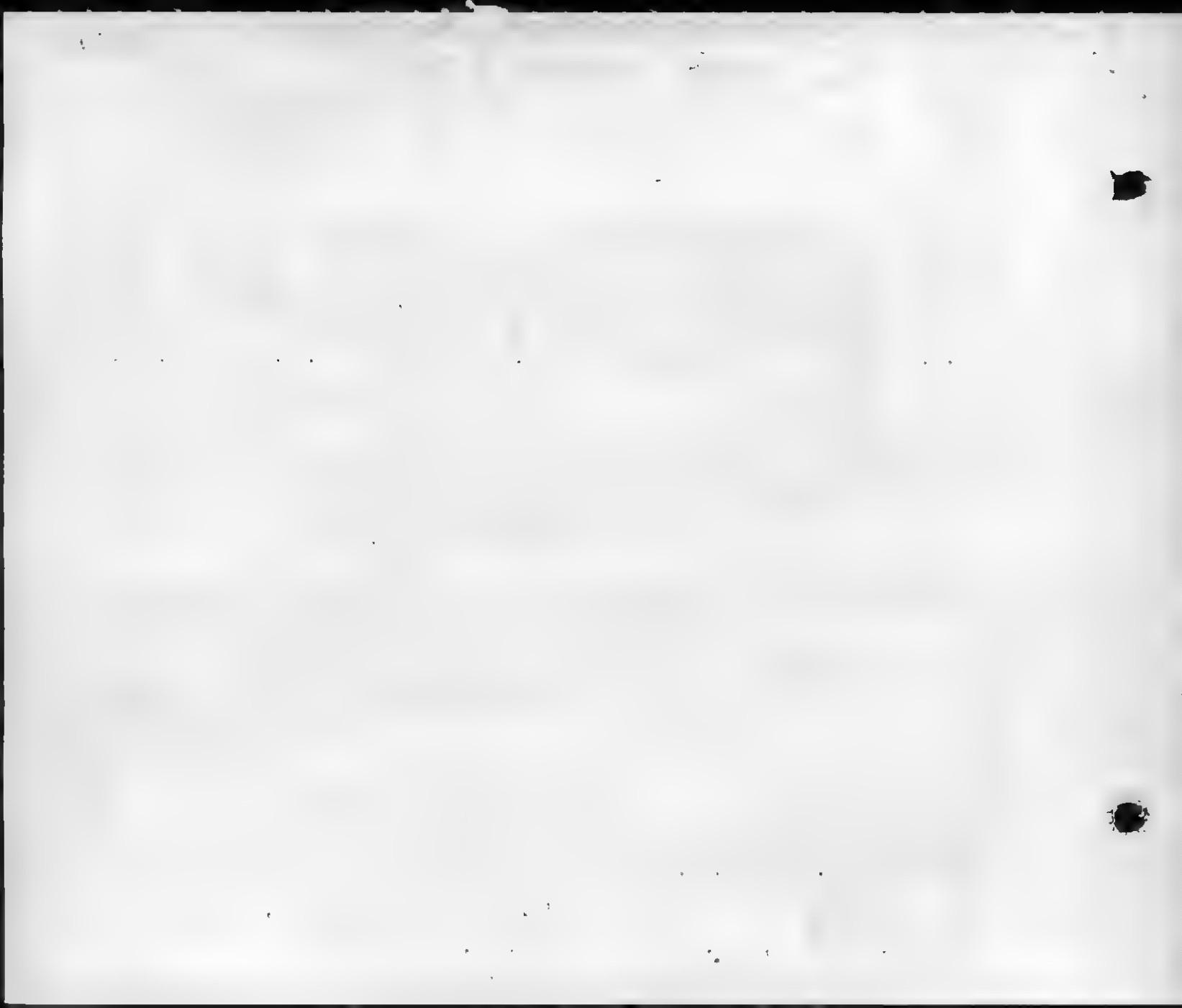
UC800

828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES EATON		First	Middle	Last	4. DATE OF DEATH CREECY	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4/9/1887	9. AGE (In years lost birthday) XX0X71 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F.C.D.A.		10b. KIND OF BUSINESS OR INDUSTRY COMMUNICATION DEPT.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME EDWARD WILLSON CREECY			14. MOTHER'S MAIDEN NAME MARGUERITTE BROWNE			Address OLNEY, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown; if yes, give war or date of service) yes VW # 1								
16. SOCIAL SECURITY NO. YES		17. INFORMANT HOSPITAL RECORDS						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) Coronary Thrombosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) SANDY SPRING (State)		
21. I certify that I attended the deceased from 1/24/59 to 1/29/59 , that I last saw the deceased alive on 1/28/59 , and that death occurred at 12:40A M, from the causes and on the date stated above								
ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND								
ACTUAL SIGNATURE 		DATE SIGNED 1/29/59						
PHYSICIAN'S NAME (Type) J. W. BIRD, M. D.								
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL 2/1/59		22b. DATE THEREOF 2/1/59		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND E. PUMPHREY INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D. BY REGISTRAR FEB 2 1959		24b. REGISTRAR'S SIGNATURE R. E. Pumphrey		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

829 CERTIFICATE OF DEATH

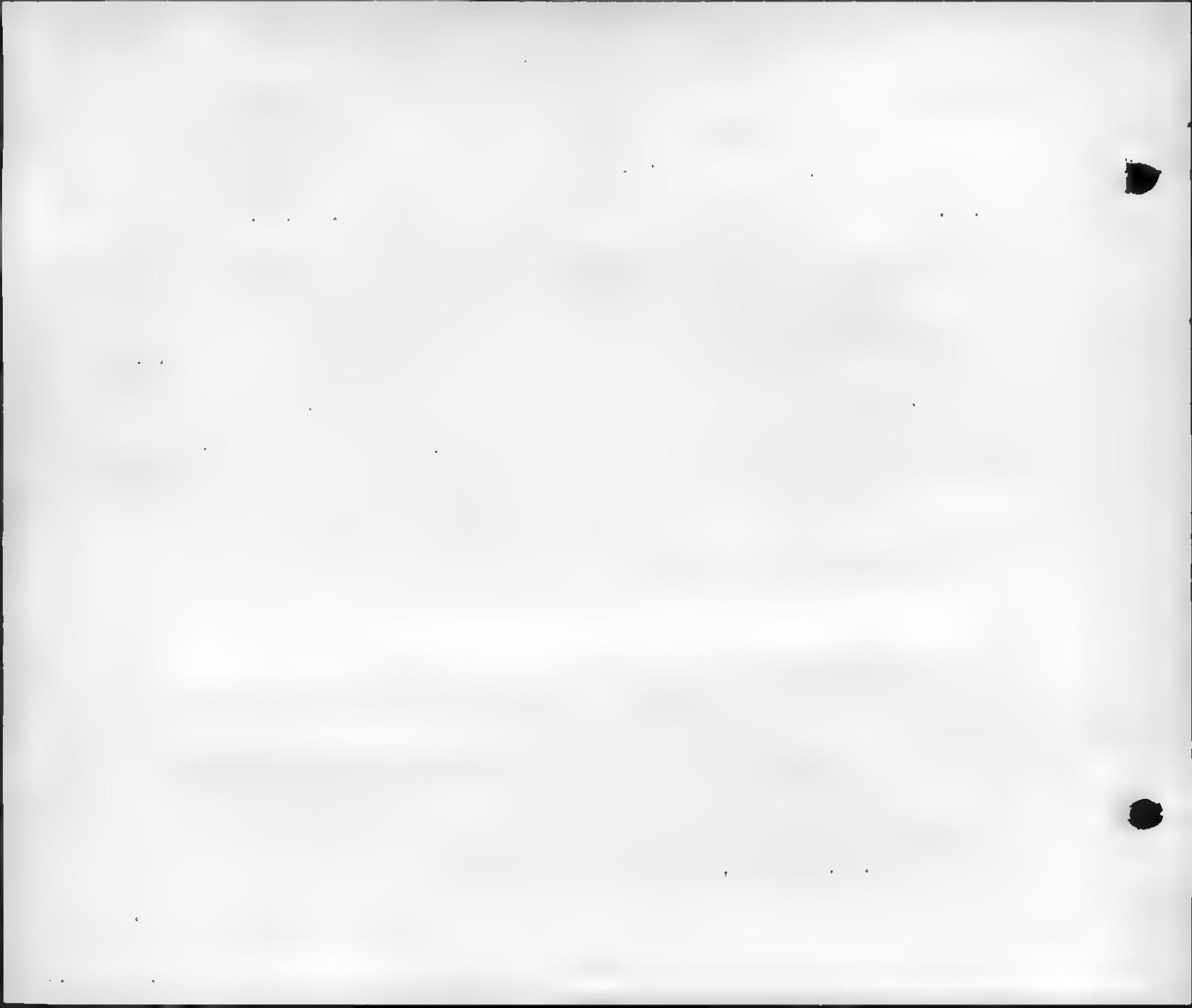
00801

Reg. Dist. No. 205

1. PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2007 Wyoming Ave., N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle Steven	Last CUMMINGS	4. DATE OF DEATH	Month January	Day 26	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 26, 1959	9. AGE (In years lost birthday) yrs. 5	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 1	12. IF UNDER 24 HRS Hours 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME David G. DAWSON				14. MOTHER'S MAIDEN NAME Joanne Anita CUMMINGS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (M) Joanne A. Cummings, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 26, 1959 , to January 26, 1959 , that I last saw the deceased alive on January 26, 1959 , and that death occurred at 9:40 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Howard A. Pearson</i>		M.D. U. S. Naval Hospital, NNMC 1-27-59					
PHYSICIAN'S NAME (Type) H. A. PEARSON, LT. MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams</i>		ADDRESS Adams Funeral Home, 4748 Wisc. Ave. NW, Washington DC		24a. REC'D BY REGISTRAR FEB 4 '59		24b. REGISTRAR'S SIGNATURE <i>John Adams</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00802

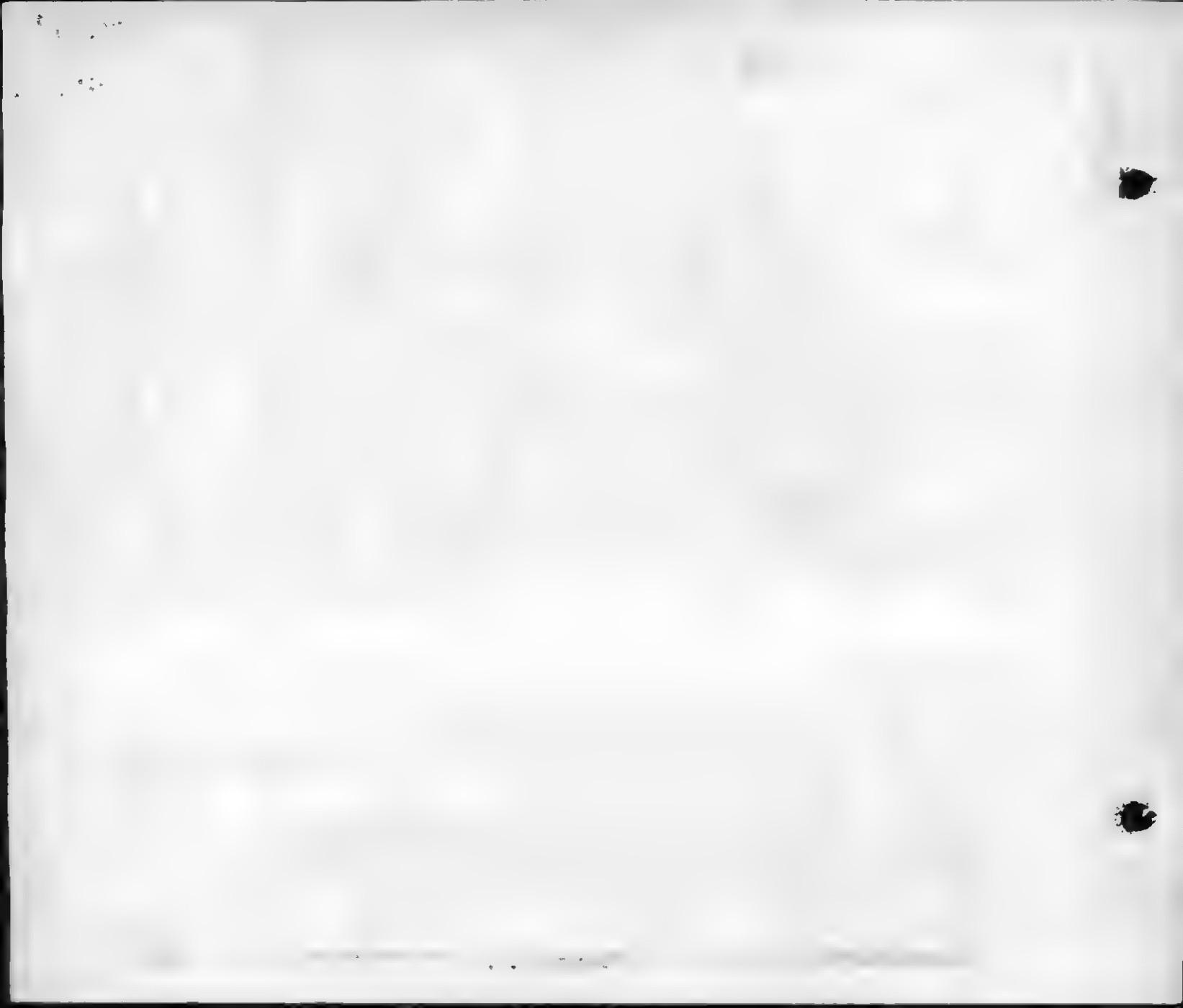
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending". In pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. File pages 1 and 2 with the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be given as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE [Where deceased lived if institution residence before admission] b. STATE <i>District of Columbia</i>	
c. LENGTH OF STAY IN 1b <i>Takoma Park 19da.</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington & Hopf</i>		e. STREET ADDRESS <i>4722 Quarles St.</i>	
3. NAME OF DECEASED (Type or print) <i>Hugh Hunter Cunningham</i>		f. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX <i>Male</i>	4. COLOR OR RACE <i>Caucasian</i>	5. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	6. DATE OF BIRTH <i>8-21-36</i>
7. WIDOWED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>22 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Floyd Cunningham</i>		14. MOTHER'S MAIDEN NAME <i>Maurice Quarrel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Hopf Record</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEART FAILURE, ACUTE, CONGESTIVE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>LEFT PLEURITIS, PERICARDITIS AND EPICARDITIS, ACUTE</i> (b) DUE TO <i>THORACOTOMY, EMERGENCY, DUE TO CARDIAC</i> (c) <i>ARREST DURING SURGERY</i>	
		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>	
		20. PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
21. TIME OF INJURY Month, Day, Year Hour <i>8 a.m. 12-22 1958</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Clothes caught fire while standing by a donkey</i>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Burden</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Albion Spring, Mont. Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DATE SIGNED <i>1-11-59</i>	
22e. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>1/16/58</i>	
22g. NAME OF CEMETERY OR CREMATORIAL <i>30 H Street, N.E.</i>		22h. LOCATION (City, town, or county) <i>Columbia, South Carolina</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Edwards</i>		24a. ADDRESS <i>30 H Street, N.E.</i>	
		24b. REC'D BY REGISTRAR <i>JAN 13 '59</i>	
		24c. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

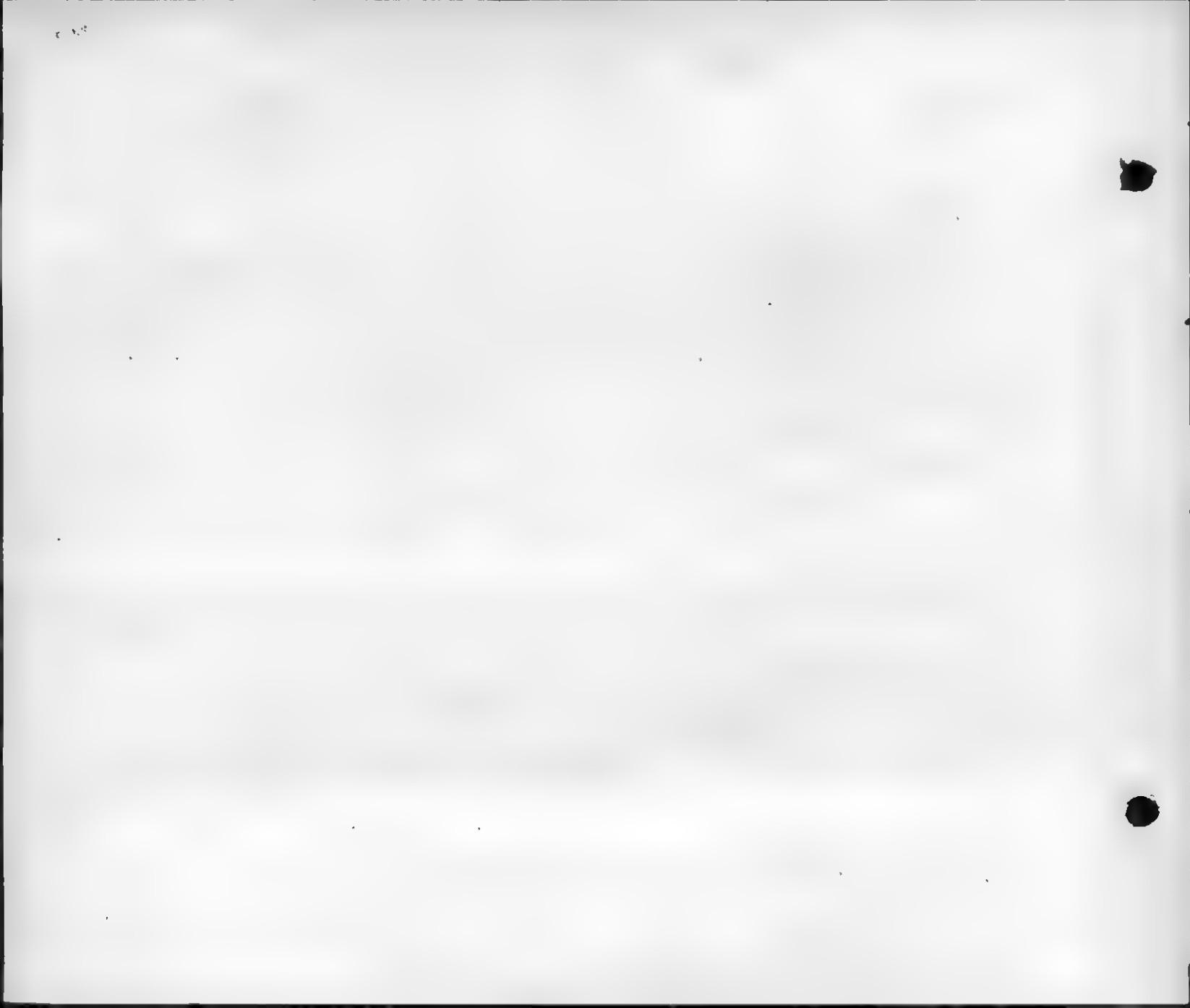
00803

830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia		b. COUNTY Alexandria		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 211 West Walnut Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph Stephen DAVITT		First	Middle	Last	4. DATE OF DEATH January 20 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-05	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Dept.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Stephen DAVITT		14. MOTHER'S MAIDEN NAME Mary FALETTE				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1924-1930		17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia DUE TO 162.1 INTERVAL BETWEEN ONSET AND DEATH 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pancoast Tumor of Lung, left DUE TO 6 months (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 1, 1958 , to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 1-20-59								
ACTUAL SIGNATURE <i>M. W. Wood</i>		M.D. U. S. Naval Hospital, NNMC 1-20-59						
PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR MC, USN		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORIUM UNK. - W.A.P.		22d. LOCATION (City, town, or county) (State) Danville Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i>		ADDRESS 4812 Ga. Ave, NW, Washington		DC		24a. REC'D BY REGISTRAR DATE JAN 22 '59	24b. REGISTRAR'S SIGNATURE <i>Charles L. Knobell</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

OC804

835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived 11 institution Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Gaithersburg (rural)		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (rural)	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Danial B.	Middle Day	4. DATE OF DEATH Month Jan. 19, 1959 Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1881
9. AGE (In years 100 days) 77 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Lawson Day		
14. MOTHER'S MAIDEN NAME Elizabeth Nicholson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		
16. SOCIAL SECURITY NO 218 12 7736	17. INFORMANT Lottie L. Day	Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. Chronic valvular heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic valvular heart disease years INTERVAL BETWEEN ONSET AND DEATH.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 20, 1959
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-59	22c. NAME OF CEMETERY OR CREMATORIUM Flower Hill	22d. LOCATION (City, town, or county) Redland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Royce Barber	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE JAN 23 '59	24b. REGISTRAR'S SIGNATURE John E. Tracy



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00805

832

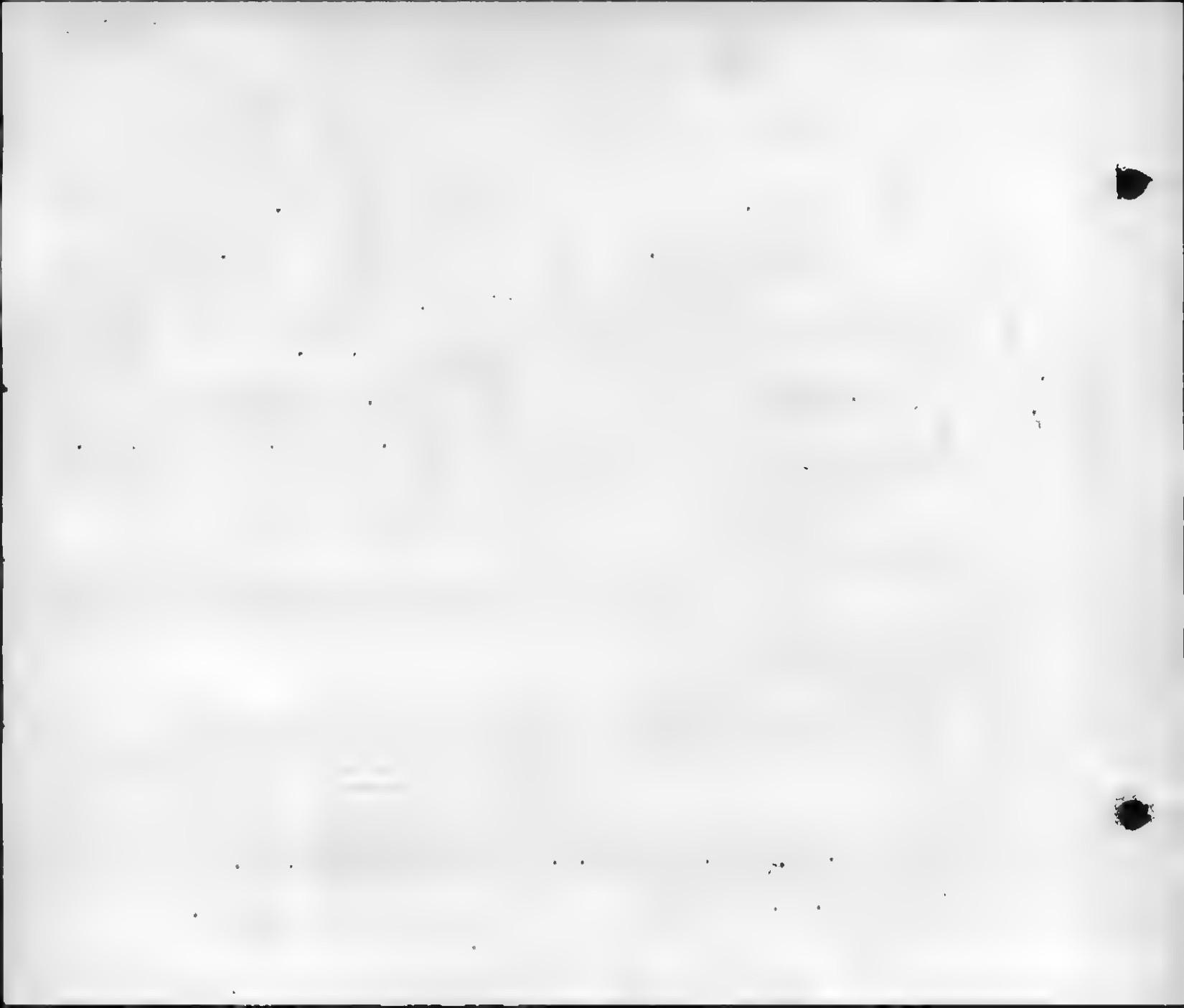
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27504 Ridge Rd.		d. STREET ADDRESS 27504 Ridge Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Ethel	Middle W.	Last Day	4. DATE OF DEATH Jan. 14	Month Jan.	Day 14	Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1876	9. AGE (in years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 82	Days 0	Hours 0	Min 0	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or Foreign country) Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Mount		14. MOTHER'S MAIDEN NAME Susan C. Molesworth							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Frances W. Moxley, Damascus, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Anteriorisclitic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 years.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Damascus		(County) Maryland	(State) Md.
21. I certify that I attended the deceased from 1/1/71 , 19 43 , to 1/14 , 19 59 , that I last saw the deceased alive on 1/13 , 19 59 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James P. Kerr</i>						ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 1/17/59	
PHYSICIAN'S NAME (Type) Dr. James P. Kerr, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Damascus		22d. LOCATION (City, town, or county) Damascus, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Molesworth</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kerr</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

833

CERTIFICATE OF DEATH

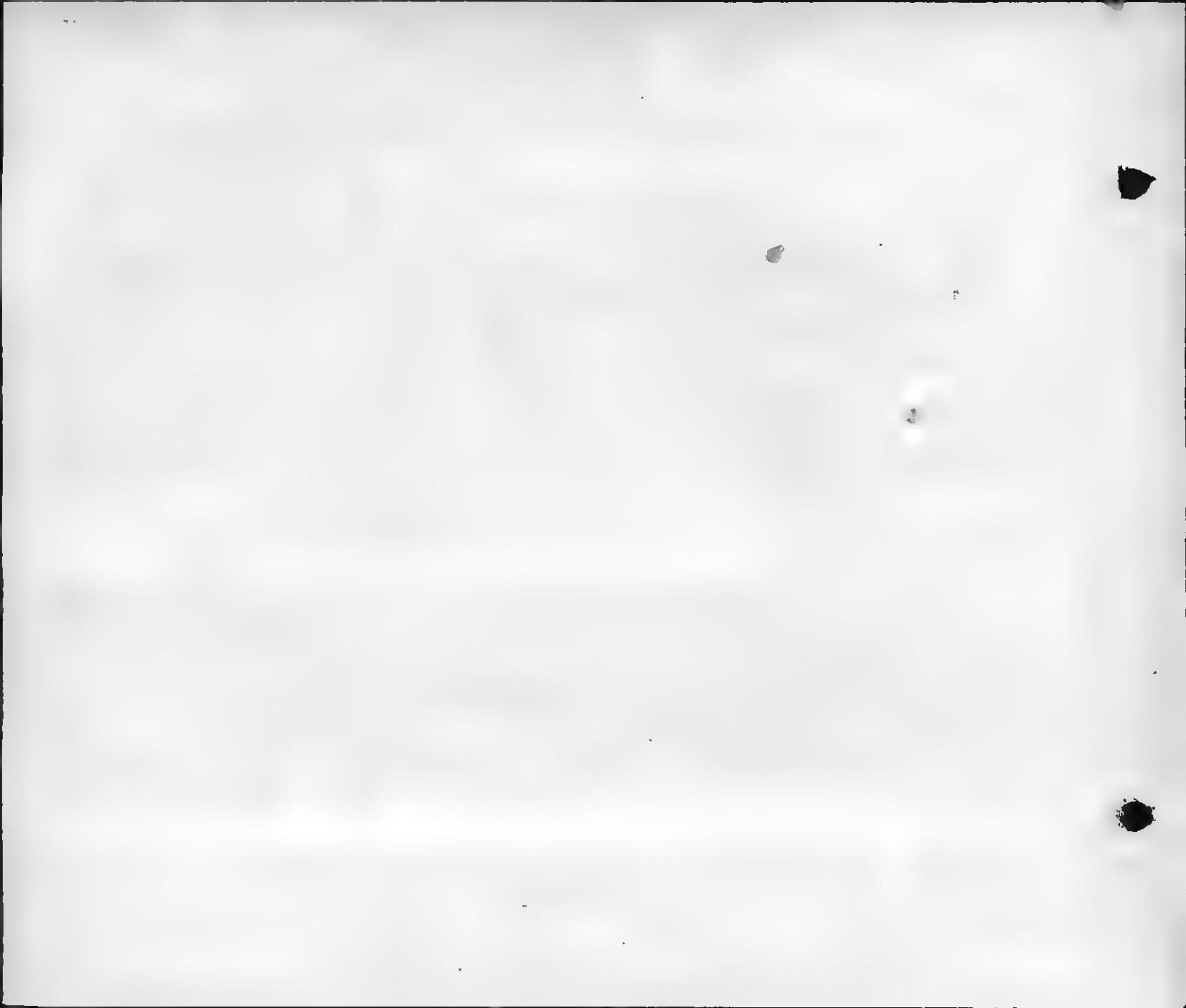
00806

Reg. Dist. No.

death: Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Florida</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hialeah</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sharon Nursing Home</i>	e. STREET ADDRESS <i>3006 San Nicholas Ave</i>						
3. NAME OF DECEASED (Type or print) <i>Carrie C. Dayton</i>	4. DATE OF DEATH Month <i>January</i> Day <i>23</i> Year <i>1959</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-6-69</i>	9. AGE (in years at last birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>9</i>	11. IF UNDER 24 HRS Days <i>17</i>	12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Montrose Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>William Chapman</i>	14. MOTHER'S MAIDEN NAME <i>Maria Jane</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>111-11-1111</i>	17. INFORMANT <i>Louise C. Tadlock</i>	Address <i>111-11-1111</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>January 19 1959</i>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>New York</i>	(County) <i>New York</i>	(State) <i>N.Y.</i>		
21. I certify that I attended the deceased from <i>1958</i> , 19, to <i>Jan 23</i> , 1959, that I last saw the deceased alive on <i>Jan 15</i> , 1959, and that death occurred at <i>74- M</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>New York, N.Y.</i>						DATE SIGNED	
ACTUAL SIGNATURE <i>Lawrence J. James M.D.</i>							
PHYSICIAN'S NAME (Type) <i>Lawrence J. James M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-24-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>New City Cemetery</i>	22d. LOCATION (City, town, or county) <i>New York, N.Y.</i>	(State) <i>N.Y.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Krause</i>	ADDRESS <i>111-11-1111</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00807

834

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o STATE Maryland - b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b - - - - -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4820 Auburn Avenue		d. STREET ADDRESS 4820 Auburn Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William Theodore Denell	Middle 	Last 	4. DATE OF DEATH January 30, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1898	9. AGE (in years from birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 7 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P Police - Retired		10b. KIND OF BUSINESS OR INDUSTRY Policeman		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William T. Denell		14. MOTHER'S MAIDEN NAME Clarett Barnes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edna Nelson Denell - as above	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first DUE TO (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease					
INTERVAL BETWEEN ONSET AND DEATH Immediate					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, Pulmonary Infections (old) Hemotorax					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956 , to January 30, 1959 , that I last saw the deceased alive on January 27, 1959 , and that death occurred at 1:50 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Edward S. Witowski, Jr. M.D. Suite 400, 1218 WISCONSIN AVE. BETHESDA 14, Md.					
ACTUAL SIGNATURE EDWARD S. WITOWSKI, JR. M.D.					
DATE SIGNED 1/30/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 3, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Potomac Methodist	
22d. LOCATION (City, town, or county) Potomac, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS 		24a. REC'D BY REGISTRAR FEB 2 '59	
				24b. REGISTRAR'S SIGNATURE Loring F. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00808

835

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in book. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Deceased had been patient at U.S. Naval Hospital from 12-29-57 to 1-30-58 and
3-23-58 to 5-29-58. Also being treated as out patient, last seen in clinic 8-15-
58. Dr. Broschart, Mont. Co. Med. Examiner notified.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		d. STREET ADDRESS Qtrs. C2, National Naval Medical Center		
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Qtrs. C2, National Naval Medical Center				f. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) Laura Francis DEWITT		First	Middle	Last	4. DATE OF DEATH January 18 1959	Month	Day	Year
5. SEX Female		6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 11-7-99	9 AGE (In years last birthday) 59 yrs	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Joseph P. FRANCIS				14. MOTHER'S MAIDEN NAME Abigail GOULD				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WVI		17. INFORMANT (H) Charles K. DeWitt, same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Infarction of myocardium				INTERVAL BETWEEN ONSET AND DEATH Immediate		
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)								
(c) DUE TO								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from January 18, 1959, to January 18, 1959, that I last saw the deceased on January 18, 1959, and that death occurred at 8:40P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) C. U. Shilling, M.D., U. S. Naval Hospital DATE SIGNED 1-19-59								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type)		C. U. SHILLING, LT, MC, USN		Bethesda 14, Maryland				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington		(State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's Sons Funeral Home, NW, Wash., DC		ADDRESS 1756 Penna. Ave		24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Clinton L. Knorr		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00803

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10208 Georgia Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hosp.</i>				4. DATE OF DEATH <i>1 - 6 1959</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Melinda Frances DiPalo</i>		First	Middle	Lost	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-12-90</i>		9. AGE (in years (at birthday) yrs.) <i>68</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Pax</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Charles Mancini</i>		14. MOTHER'S MAIDEN NAME <i>Mary Nicholas DelVecchio</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHIOGENIC CANCER, RIGHT LUNG</i> DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <i>14 mos</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE 18, 1958</i> to <i>JAN 6, 1959</i> , that I last saw the deceased alive on <i>JAN 6, 1959</i> , and that death occurred at <i>4:50 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward A. Beeman</i> M.D. ADDRESS <i>10208 GEORGIA AVE</i> DATE SIGNED							
PHYSICIAN'S NAME (Type) <i>EDWARD A. BEEMAN</i>		SILVER SPRING MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/10/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>GATE OF HEAVEN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pritchey, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>JAN 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Sur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

836

CERTIFICATE OF DEATH

00810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS Route #3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Hattie	Middle May	Last Dorsey	4. DATE OF DEATH January 10 1959	Month January	Day 10	Year 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2.7.10		9. AGE (in years last birthday) 48 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Charles Warner		14. MOTHER'S MAIDEN NAME Laura Matthews		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO 217-22-4258		17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Carcinoma of Cervix</i>		<i>Generalized pelvic metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sandy Spring, Maryland	(County) Montgomery (State) Md.
21. I certify that I attended the deceased from December 31 1958 , to January 10, 1959 , that I last saw the deceased alive on January 10, 1959 , and that death occurred at 2:43 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>J.W.B.</i>		M.D.					
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		Sandy Spring, Maryland		1.10.59			
22d. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Simpson Meth.		22d. LOCATION (City, town, or county) Poplar Springs, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Molsworth</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 59		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00811	
837 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
c. LENGTH OF STAY IN 1b 1 day					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.					d. STREET ADDRESS 103 Summitt Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Allen		First	Middle	Last	4. DATE OF DEATH January 31 1959		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-59			9. AGE (in years last birthday) yrs. 1 & 21 Hrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY United States		
13. FATHER'S NAME Edgar William Drew			14. MOTHER'S MAIDEN NAME Barbara Ann Wetherell						Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> NO		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Ann Drew							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH yes	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month Day Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sainte L. Lucy, Md.		(County) Montgomery		(State) Md.	
21. I certify that I attended the deceased from Jan. 29, 1959, to Jan. 31, 1959, that I last saw the deceased alive on Jan. 31, 1959, and that death occurred at Jewell M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Sainte L. Lucy, Md., 1-31-59	DATE SIGNED 1-31-59
ACTUAL SIGNATURE Jack Schumacher, M.D.											
PHYSICIAN'S NAME (Type) Jack Schumacher, M.D.										Gaithersburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2 59		22c. NAME OF CEMETERY OR CREMATORIUM Wutheran			22d. LOCATION (City, town, or county) Hedland			(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR C. J. Kraus			24b. REGISTRAR'S SIGNATURE C. J. Kraus				
SIXV 3											

✓ 1932

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

838 CERTIFICATE OF DEATH

Reg. Dist. No.

00812

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb Since 9/3/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CARRIE	Middle W.	Last ECKAM		
4. DATE OF DEATH	Month JAN.	Day 18	Year 19 59		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/67	9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEW YORK STATE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CLARENCE WICKHAM		14. MOTHER'S MAIDEN NAME MARIETTA PRATT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Broheim Ebbess, 12,825 Baker Drive Address Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Congestive heart failure</i> DUE TO <i>400.0</i>				INTERVAL BETWEEN ONSET AND DEATH 3 wks	
Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>generalized arteria sclerosis</i>				10 yrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Reptl</i> 1958, to <i>Jan 18, 1959</i> , that I last saw the deceased alive on <i>Jan 18, 1959</i> , and that death occurred at <i>11:15 AM</i> , from the causes and on the date stated above. ACTUAL DATE <i>18 Jan 59</i>				ADDRESS (Street, city or town, state) <i>7852 16th Ave, Wal 12 11/15/59</i>	
PHYSICIAN'S NAME (Type) <i>H F Kreuzburg</i>		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (SUCH) ENTOMBMENT 1/20/59		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN MAUSOLEUM	
22d. LOCATION (CITY, TOWN OR COUNTY) (State) PRINCE GEO. COUNTY, MARYLAND					
23. FUNERAL DIRECTOR'S SIGNATURE, INC. <i>Reynard L. Ziska</i>		ADDRESS STEVENS SPRING, MD.		24a. REC'D BY REGISTRAR JAN 21 '59 DATE	
				24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

839 CERTIFICATE OF DEATH

00813

Reg. Dist. No.

TO HOSPITAL OR ATTENDIG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) d. STATE Virginia		b. COUNTY Norfolk		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Norfolk		d. STREET ADDRESS 617 B Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elsie Lee Eckleberry		First	Middle	Last	4. DATE OF DEATH January 2, 1959	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900	9. AGE (In years from birthday) 58 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Benjamin Winn		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from December 1, 1958 , to January 2, 1959 , that I last saw the deceased alive on January 2, 1959 , and that death occurred at 6:15 AM , from the causes and on the date stated above ACTUAL SIGNATURE <i>Arthur T. Teplitzky</i> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 1-2-59		
PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Itansit		22b. DATE THEREOF 1/2/59		22c. NAME OF CEMETERY OR CREMATORIUM Riverside		22d. LOCATION (City, town, or county) (State) Norfolk, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE <i>L. L. ... & Graff</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

840

CERTIFICATE OF DEATH

00814

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5921 Beech Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5921 Beech Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Karl Valentine		First	Middle	Last	4. DATE OF DEATH Eiken Jr	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1921	9. AGE (In years last birthday) 37 yrs	10. IF UNDER 1 YEAR Months 8	Days 19	11. IF UNDER 24 HRS. Hours 21	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Karl V. Eiker, Sr.		14. MOTHER'S MAIDEN NAME Martha King							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2		17. INFORMANT Winifred A. Eiker-wife-same as 2d		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO multiple cerebral hemorrhages				INTERVAL BETWEEN ONSET AND DEATH 6 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO congenital telangiectasis				37 yrs			
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7852 16th St. N. W. Washington DC		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 2, 1959 , to Jan 2, 1959 , that I last saw the deceased alive on Jan 2, 1959 , and that death occurred at 84 M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 7852 16th St. N. W. Washington DC		DATE SIGNED 1/26/59	
ACTUAL SIGNATURE <i>H.F. Kreuzburg</i>		M.D.							
PHYSICIAN'S NAME (Type) H.F. Kreuzburg									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 23 3		24b. REGISTRAR'S SIGNATURE <i>J. A. Pumphrey</i>			
VS A15 (4) 15M 9/55									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

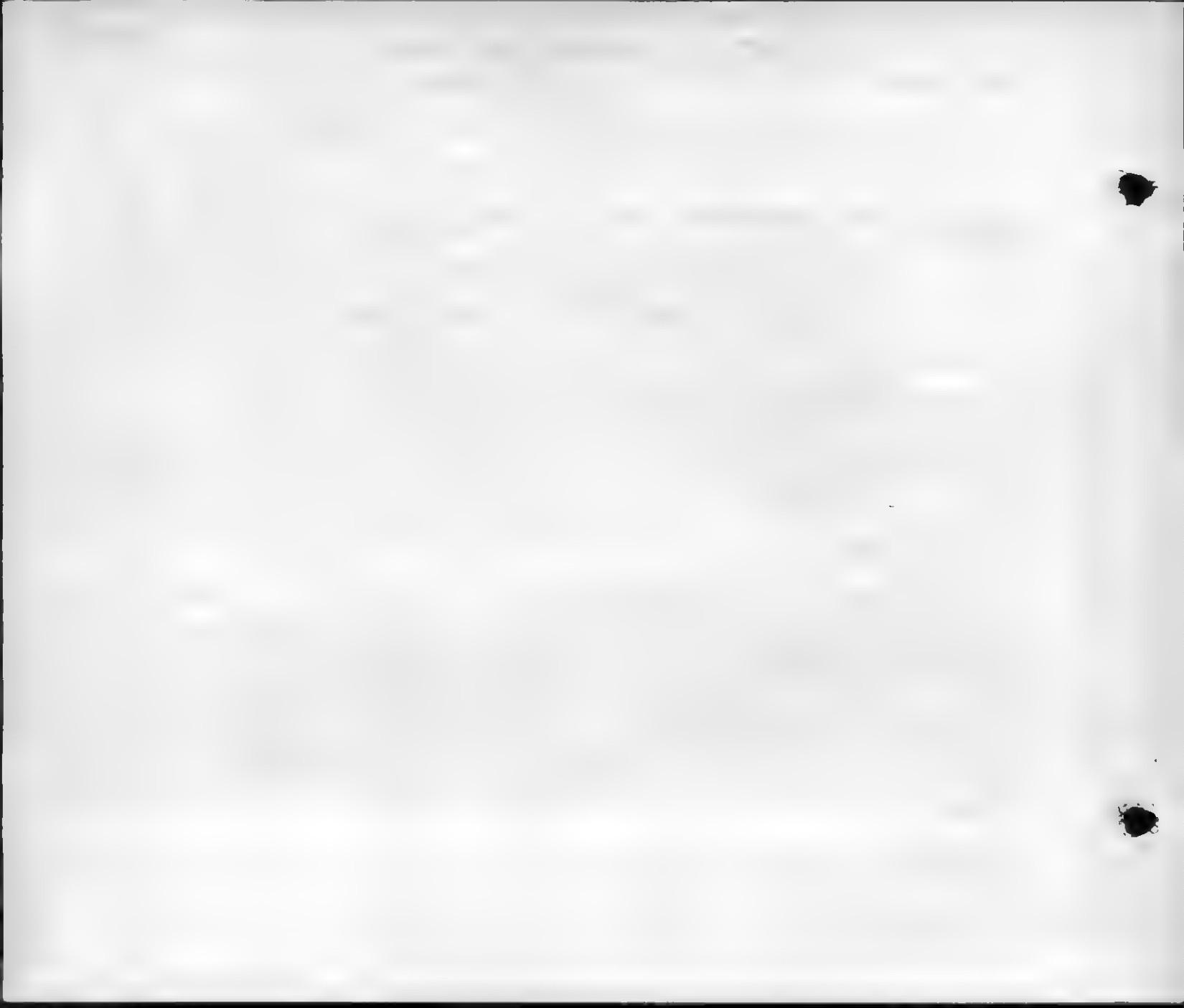
765

CERTIFICATE OF DEATH

00815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson Park</i>		c. LENGTH OF STAY IN 1b <i>Rural and give nearest town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friedrichsburg</i>		d. STREET ADDRESS <i>812 W. Main St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Park Sanatorium Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Annie</i>	Middle <i>Geraldine</i>	Last <i>Ellis</i>	4. DATE OF DEATH	Month <i>2</i>	Day <i>1</i>	Year <i>1959</i>
5. SEX <i>f</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/26/04</i>	9. AGE (In years last birthday) <i>14 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hospital</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George William Nicholson</i>		14. MOTHER'S MÄDEN NAME <i>Jeanne Lewis</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>P.H. hosp. Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i>		DUE TO <i>Diabetes - Glucose Hopkins</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Diabetes - Glucose</i>				1 day			
(c) <i>Diabetes - Glucose</i>				1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Frederickburg, Va.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-11-59</i> , to <i>1-21-59</i> , that I last saw the deceased alive on <i>1-21-59</i> , and that death occurred at <i>9120 FM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>1/24/59</i>	
ACTUAL SIGNATURE <i>Robert F. Hare</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>Robert F. Hare, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/22/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Towson Park, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>FREDRICKSBURG, VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Avery</i>		ADDRESS <i>8 King St., Attn. 2</i>		24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE <i>J. E. Avery</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>3 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green belt</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash San + Hosp.</i>		d. STREET ADDRESS <i>116 Northway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Ella</i>		First	Middle <i>Louise</i>	Last <i>Engelhardt</i>	4. DATE OF DEATH <i>January 19</i>	Month <i>January</i>	Day <i>19</i>	Year <i>1969</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-11-94</i>	9. AGE (In years from last birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary to husband</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naturopath</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>					
13. FATHER'S NAME <i>Charles Pungar</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>577-52-8477</i>		17. INFORMANT <i>Husband - by chart</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <i>Secular disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>			
171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO <i>Exacerbation of disease</i>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>12-16-1958</i> , to <i>1-14-1959</i> , that I last saw the deceased alive on <i>1-17-1959</i> , and that death occurred at <i>6:20 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>1/18/59</i>			
MEDICAL CERTIFICATION MEDICAL SIGNATURE <i>R. Lincoln Crematory M.D.</i>									
PHYSICIAN'S NAME (Type) <i>R. Lincoln Crematory M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1/20/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) <i>Prince Georges County, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Hanes Co.</i>		ADDRESS <i>2901-14 St. N.W.</i>		24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE <i>John Hanes</i>			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

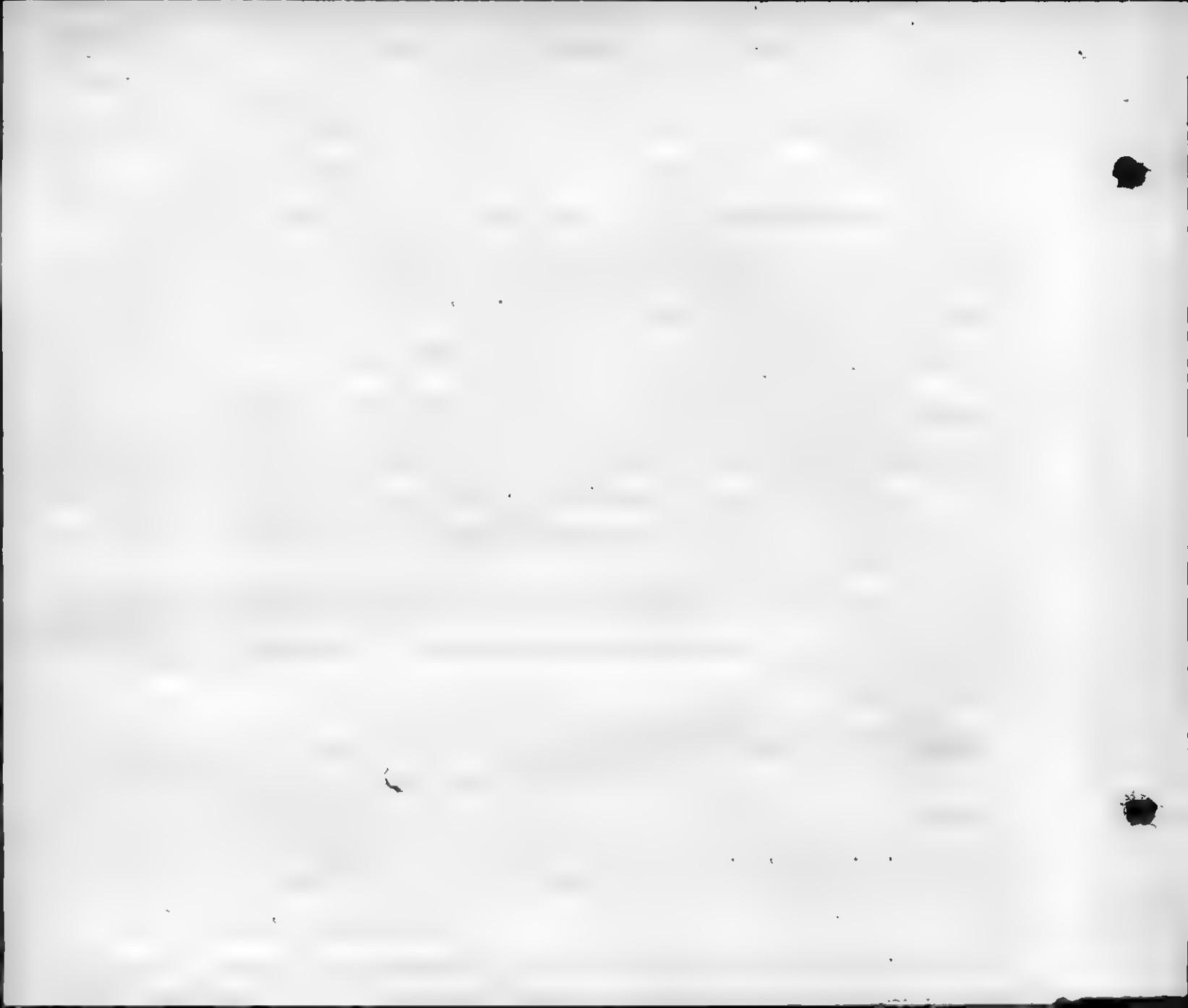
841

CERTIFICATE OF DEATH

Reg. Dist. No.

00817

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i>		b. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4706 Jamestown Road</i>		e. STREET ADDRESS <i>4706 Jamestown Rd., Bethesda</i>	
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>frances</i>
4. DATE OF DEATH		Month <i>Jan.</i>	Day <i>19</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 17, 1958</i>		9. AGE (in years last birthday) <i>XXXXXX</i>	10. IF UNDER 1 YEAR Months <i>3</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>			
13. FATHER'S NAME <i>William J. Evans</i>		14. MOTHER'S MAIDEN NAME <i>Mary Alice Hollyfield</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT		Address <i>Dr. Tilley's Office</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
DUE TO <i>5272</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Respiratory Infection</i>			
(c) <i>12-24 hrs.</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>OCTOBER 1958</i> to <i>1-19</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-19</i> , 19 <i>59</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>4701 Mass. Ave. NW</i>	
ACTUAL SIGNATURE <i>R. M. Tilley, Jr.</i>		DATE SIGNED <i>1-20-59</i>	
PHYSICIAN'S NAME (Type) <i>R. M. Tilley, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur. Transit</i>		22b. DATE THEREOF <i>1/21/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Frankfort</i>		22d. LOCATION (City, town, or county) <i>Frankfort, Kentucky</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>JAN 23 1959</i>	24b. REGISTRAR'S SIGNATURE <i>R. S. Tilley</i>
VS A15 (4) 15M 9/55			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

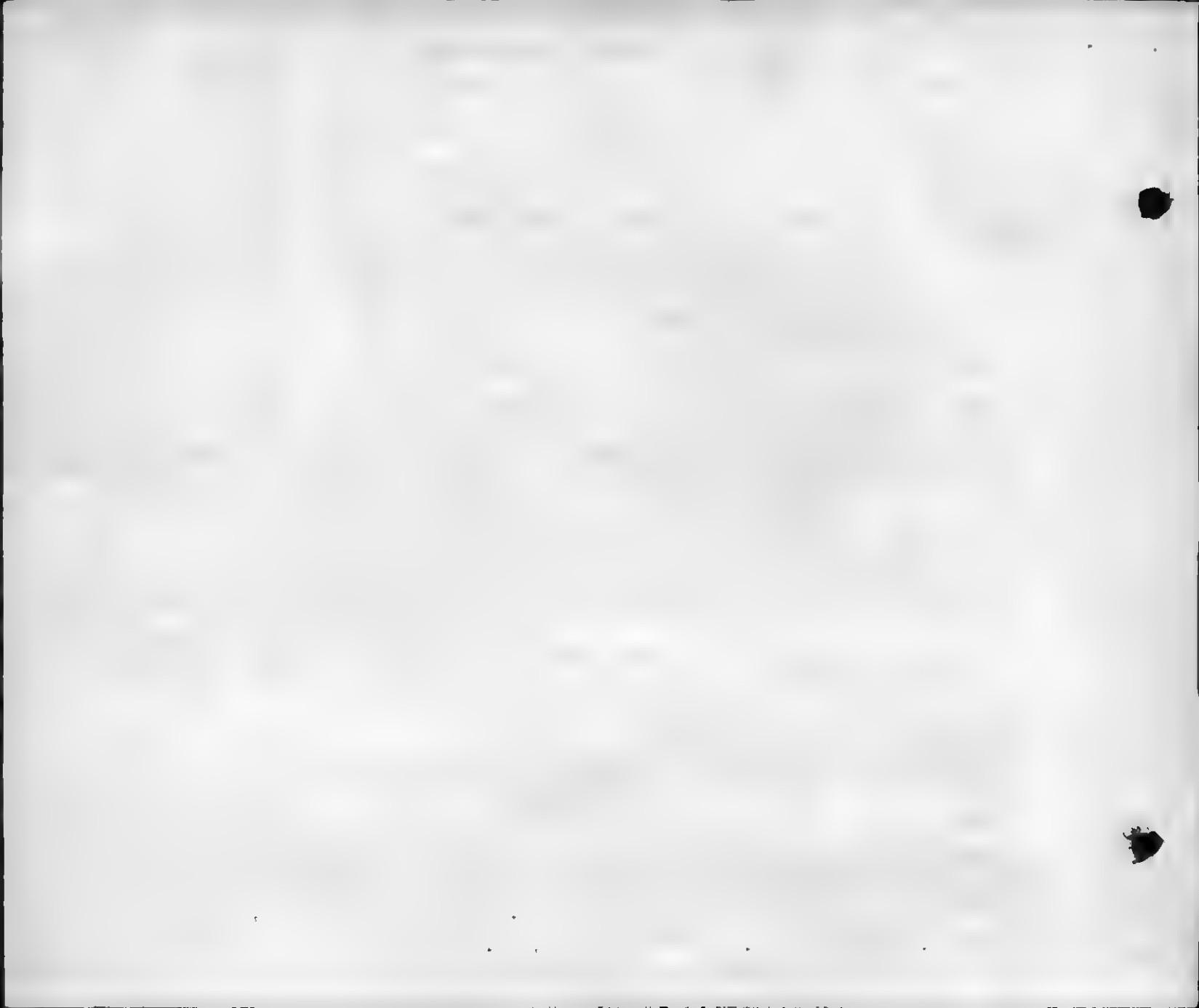
842

CERTIFICATE OF DEATH

Reg. Dist. No.

00818

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 12 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8809 BRADFORD ROAD.		d. STREET ADDRESS 8809 BRADFORD ROAD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS EDWARD FAHY JR.	First Middle Last	4. DATE OF DEATH JANUARY 18 1957	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1904
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Engineer.		10b. KIND OF BUSINESS OR INDUSTRY Heating	
10c. BIRTHPLACE (State or foreign country) YONKERS, Pa.		11. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS E. FAHY		14. MOTHER'S MAIDEN NAME ANNIE REAGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> War or date of service		16. SOCIAL SECURITY NO. 181-07-5192 17. INFORMANT JACK FAHY 4709 Boiling Brook Pkwy Rockville, MD Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Ventricular fibrillation INTERVAL BETWEEN ONSET AND DEATH Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last } (b) DUE TO Coronary Occlusion Sudden		} (c) DUE TO Coronary artery Disease 24 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 23 1957, to JAN 18 1957, that I last saw the deceased alive on Jan. 18 1957, and that death occurred at 10:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James A. Roberts M.D. 8707 GEORGIA AVENUE. 1/18/59. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS SILVER SPRING, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/21/59	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS WALTER E. PUMPKIN, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 21 1959	24b. REGISTRAR'S SIGNATURE C. M. L. Hause
VS A15 (4) 15M 9/55			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00819

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 5613 Belmont Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Effie		First Brooke	Middle Falck	Last Jan	DATE OF DEATH 29	Month 1959	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1887	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Brooke		14. MOTHER'S MAIDEN NAME Mary L. Arnold		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. J. Stanley Falck	
17. INFORMANT 5613 Belmont Ave. Chevy Chase, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF CECUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 153.0 (b) Metastases to Regional Lymph Nodes DUE TO (c) Liver and Lungs.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1958 , to January 29, 1959 , that I last saw the deceased alive on January 28, 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Washington Clinic, Washington DC		ACTUAL SIGNATURE Michael M. Tracy		DATE SIGNED 1/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cem.		22d. LOCATION (City, town, or county) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home		ADDRESS 5703 Wisconsin Ave.		24a. REC'D BY REGISTRAR FEB 2 '59		24b. REGISTRAR'S SIGNATURE John J. Quinn	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00820

844

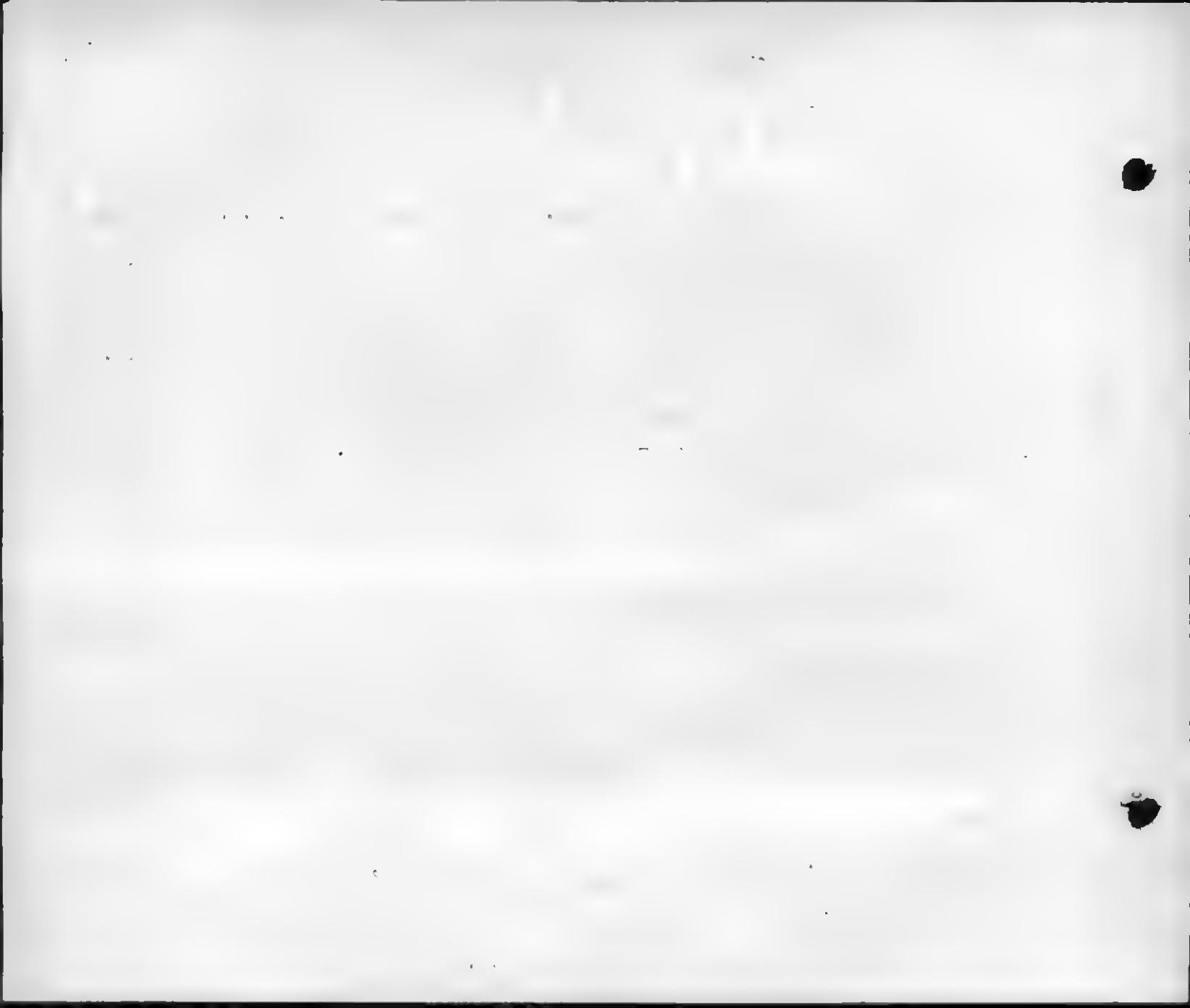
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, District of Columbia		d. STREET ADDRESS 3011 Clinton Street, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie		First	Middle Reeves	Last Fequa	4. DATE OF DEATH Month January	Day 11,	Year 19 59
S. SEX Female	6 COLOR OR RACE Negroe	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH February 17, 1912	9 AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Bezail White				14. MOTHER'S MAIDEN NAME Virginia Wards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) No		16. SOCIAL SECURITY NO. 578-44-0784		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Lymphoblastic, lymphosarcoma				INTERVAL BETWEEN ONSET AND DEATH 2½ years			
3.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
21. I certify that I attended the deceased from January 2, 1959 , to January 11, 1959 , that I last saw the deceased alive on January 11, 1959 , and that death occurred at 3:45 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James M. Marsh, M.D.</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) JAMES M. MARSH, M.D.		DATE SIGNED 1/11/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/59		22c. NAME OF CEMETERY OR CREMATORIUM New Hope Cemetery		22d. LOCATION (City, town, or county) (State) New Hope, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James M. Marsh - 30 H Street, N.E.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 13 '59		24b. REGISTRAR'S SIGNATURE <i>Carrie S. T. Marshall</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821

845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN b. <i>2 1/2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>571 University Drive</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lvella</i>	First	Middle	Last <i>Finnell</i>
4. DATE OF DEATH <i>JANUARY 18</i>	Month	Day	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-1872</i>
9. AGE (In years last birthday) <i>86</i>	10. IF UNDER 1 YEAR Months <i>86 yrs.</i>	11. IF UNDER 24 HRS Days <i>0 hrs.</i>	12. IF UNDER 24 HRS Hours <i>0 min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Connor Pulliam</i>		14. MOTHER'S MAIDEN NAME <i>Luzetta Pulliam</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mrs Ruth Poetzman</i>	
17. INFORMANT <i>Mrs Ruth Poetzman</i>		Address <i>10601-Kinlock Rd. S.S. #10</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i> DUE TO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 300-Hamilton St. N.W. Washington D.C.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-12, 1959</i> to <i>1-18, 1959</i> , that I last saw the deceased alive on <i>1-18, 1959</i> , and that death occurred at <i>645 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S.P. Porton</i>		ADDRESS (Street, city or town, state) <i>Woodstock, Va.</i>	
PHYSICIAN'S NAME (Type) <i>S.P. Porton</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-21-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Massanutton</i>	22d. LOCATION (City, town, or county) (State) <i>Woodstock, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.L. Bellinger</i>		24a. REC'D BY REGISTRAR <i>John E. Thomas</i>	24b. REGISTRAR'S SIGNATURE
ADDRESS <i>Woodstock, Va.</i>		DATE REC'D <i>Jan 20 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Log No. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00822

846

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>minutes</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Suburbans</i> <i>5015 Aspen Hill Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cecile A Fitzpatrick</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Cecile</i>	First <i>A</i>	Middle <i>Fitzpatrick</i>	Last DATE OF DEATH 1 8 1959
4. SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Dec 30 1894</i>
8. AGE (In years last birthday) <i>65 yrs.</i>		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Kelly</i>	
14. MOTHER'S MAIDEN NAME <i>Bradley</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Frances Hewitt - Daughter - Son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15-30 min.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>416X</i>		(b) <i>Rheumatic Heart Disease (Myopathy).</i>	
DUE TO <i>—</i>		(c) <i>18 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>57</i> , to <i>January 8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>January 8</i> , 19 <i>59</i> , and that death occurred at <i>837 Bonifant St. Silver Spring, Md.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.B. Wardrop MD</i>		ADDRESS (Street, city or town, state) <i>837 Bonifant St. Silver Spring, Md.</i> DATE SIGNED <i>1/15/59</i>	
PHYSICIAN'S NAME (Type) <i>W. B. WARDROP, MD</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON VA.</i> (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> <i>1/12/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON HALT</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Warren Tallantell</i>		24a. REC'D BY REGISTRAR ADDRESS <i>3603-14-81 N.C.</i> DATE <i>JAN 12 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791

CERTIFICATE OF DEATH

00823

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, or removal, in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Holmes</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Delco</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.		c. LENGTH OF STAY IN lb <i>15 1/2 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longmeadow Hospital & Rehabilitation</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
3. NAME OF DECEASED (Type or print) Ethel		First D.	Middle Foster
4. DATE OF DEATH <i>8/11/72</i>	Month 1	Day 10	Year 1972
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/11/72</i>
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR 4	11. IF UNDER 24 HRS. 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Name-maker		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard DeWitt		14. MOTHER'S MAIDEN NAME Ethel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter, Friend, Tenant		Address 4201 Reservoir St. N.W. Washington 16.D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHIAL PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -	
20c. TIME OF INJURY Hour o. n. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) M.D. 4201 Reservoir St. N.W. Washington 16.D.C.
21. I certify that I attended the deceased from JUNE , 19 55 , to JAN 10 , 19 59 , that I last saw the deceased alive on JAN 10 , 19 59 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-10-59 DATE SIGNED			
ACTUAL SIGNATURE <i>P.P. Andrews M.D.</i>	PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-59	22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem.	22d. LOCATION (City, town, or county) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE 11-4-59	24b. REGISTRAR'S SIGNATURE <i>C. L. Knob</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

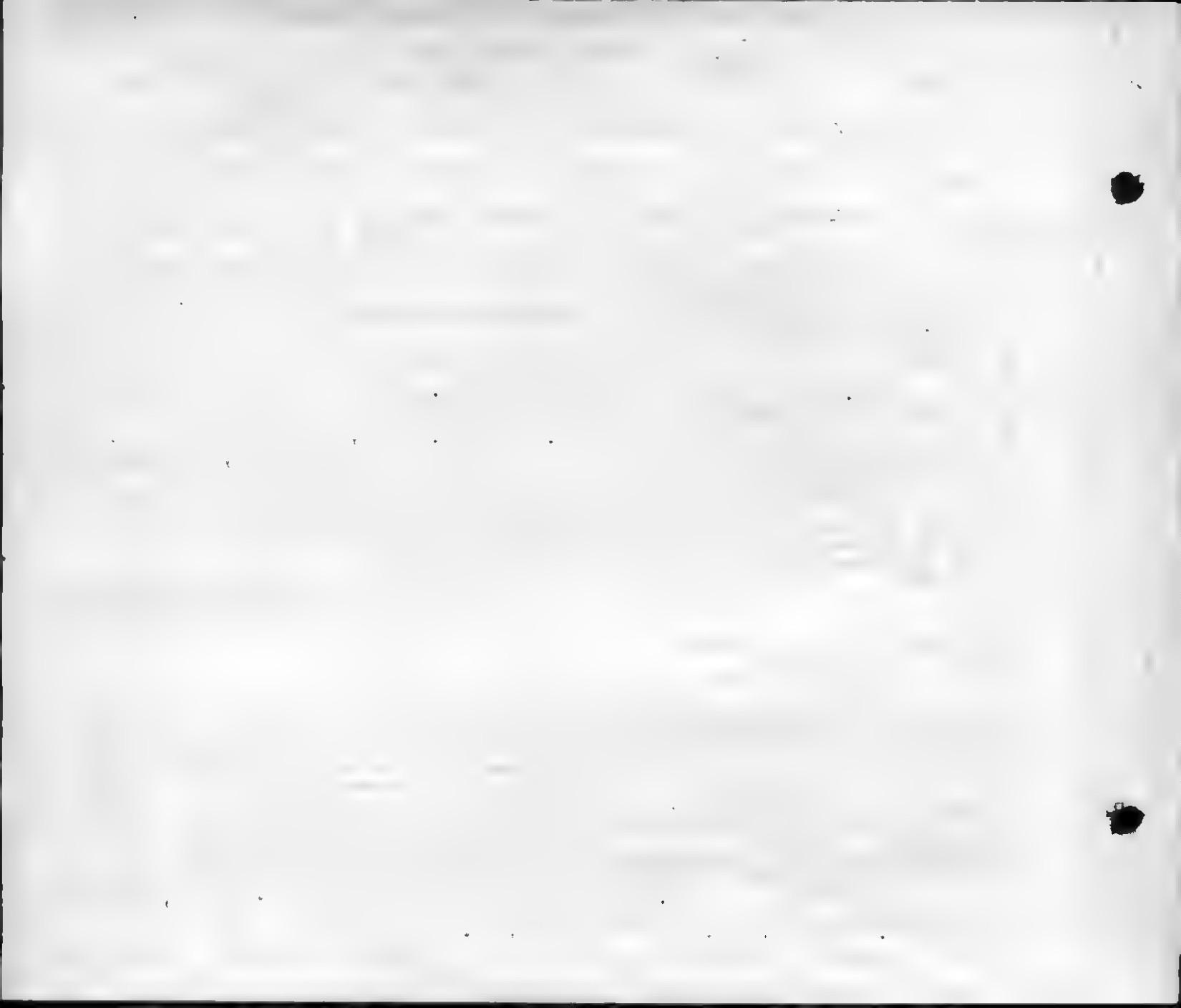
00824

CERTIFICATE OF DEATH

Reg. Dist. No.

792

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>5720 Crawford Drive</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5720 Crawford Drive.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Karen Lee.</i>		First	Middle	Last	4. DATE OF DEATH <i>Frick</i>	Month <i>JAN</i>	Day <i>20</i>	Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 9, 1959</i>		9. AGE (In years lost birthday) yrs. <i>11</i>		IF UNDER 1 YEAR Months <i>11</i>	IF UNDER 24 HRS. Days <i>11</i>	Hours <i>11</i>	Min. <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Gerald P. Frick</i>		14. MOTHER'S MAIDEN NAME <i>Lois L. Whiteman</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Gerald P. Frick, 5720 Crawford Drive,</i>		Address <i>Rockville, Maryland</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7545 Congestive heart failure</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>		(b) <i>Congenital heart disease (Hypertrophy of the aorta)</i>		DUE TO <i>(c)</i>		ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>345 University Boulevard, No. 7</i>		20f. (City or town) <i>Silver Spring, Md.</i>		(County) <i>Silver Spring</i>		(State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>JAN 15, 1959</i> , to <i>Jan 20, 1959</i> , that I last saw the deceased alive on <i>Jan 20, 1959</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above											
ADDRESS (Street, city or town, state) <i>345 University Boulevard, No. 7, Silver Spring, Md.</i>											
DATE SIGNED <i>1/20/59</i>											
ACTUAL SIGNATURE <i>Raymond Bradshaw</i>		PHYSICIAN'S NAME (Type) <i>Raymond Bradshaw</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (Cty. town, or county) <i>PRINCE GEO. COUNTY, MARYLAND</i>		(State)			
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22f. DATE THEREOF <i>1/22/59</i>		22g. RECD BY REGISTRAR DATE <i>JAN 22 '59</i>		22h. REGISTRAR'S SIGNATURE <i>C. S. Kara</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>									
<i>Raymond E. Ziska</i>											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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847

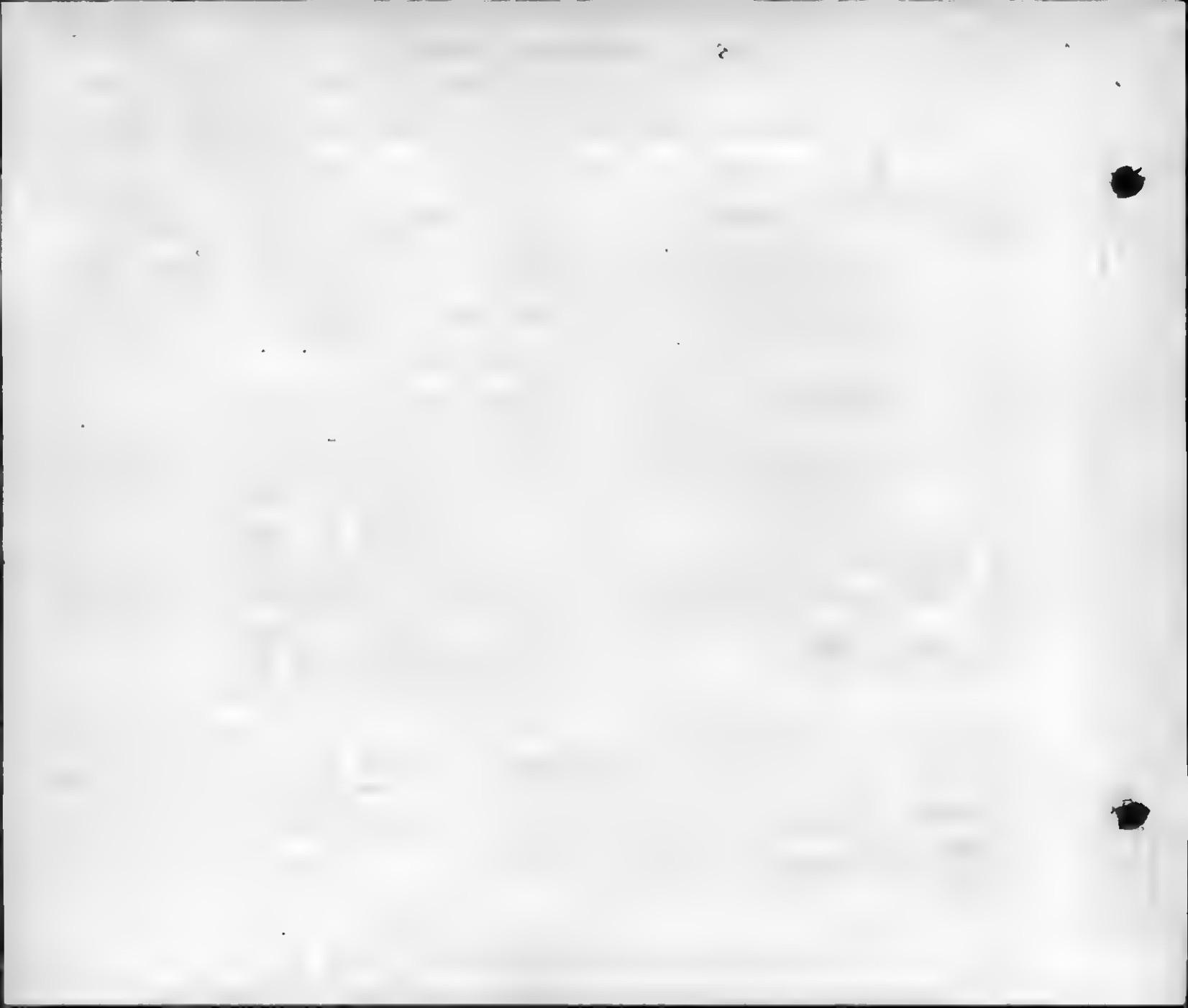
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6206 Singleton Place		d. STREET ADDRESS 6206 Singleton Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES First Middle V. FRISBIE		4. DATE OF DEATH	Month January Day 22, Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 24, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) yrs 86	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		10. IF UNDER 1 YEAR Months 7 Days 28 Hours Min.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Barnes		14. MOTHER'S MAIDEN NAME Rose Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Kenneth W Frisbie		7803 Stratford Rd. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO		Myocardial Infarction, Acute	
(b) DUE TO		Coronary arteriosclerosis, severe 10 yrs +	
(c) DUE TO		Arteriosclerosis, generalised 10 yrs +	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1946, to Jan 22, 1959, that I last saw the deceased alive on Jan 13, 1959, and that death occurred at 10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) M.D. 3921 Ingomar St. Wash 15 DC DATE SIGNED 1.22.59	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 26 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Cathie L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, or any other event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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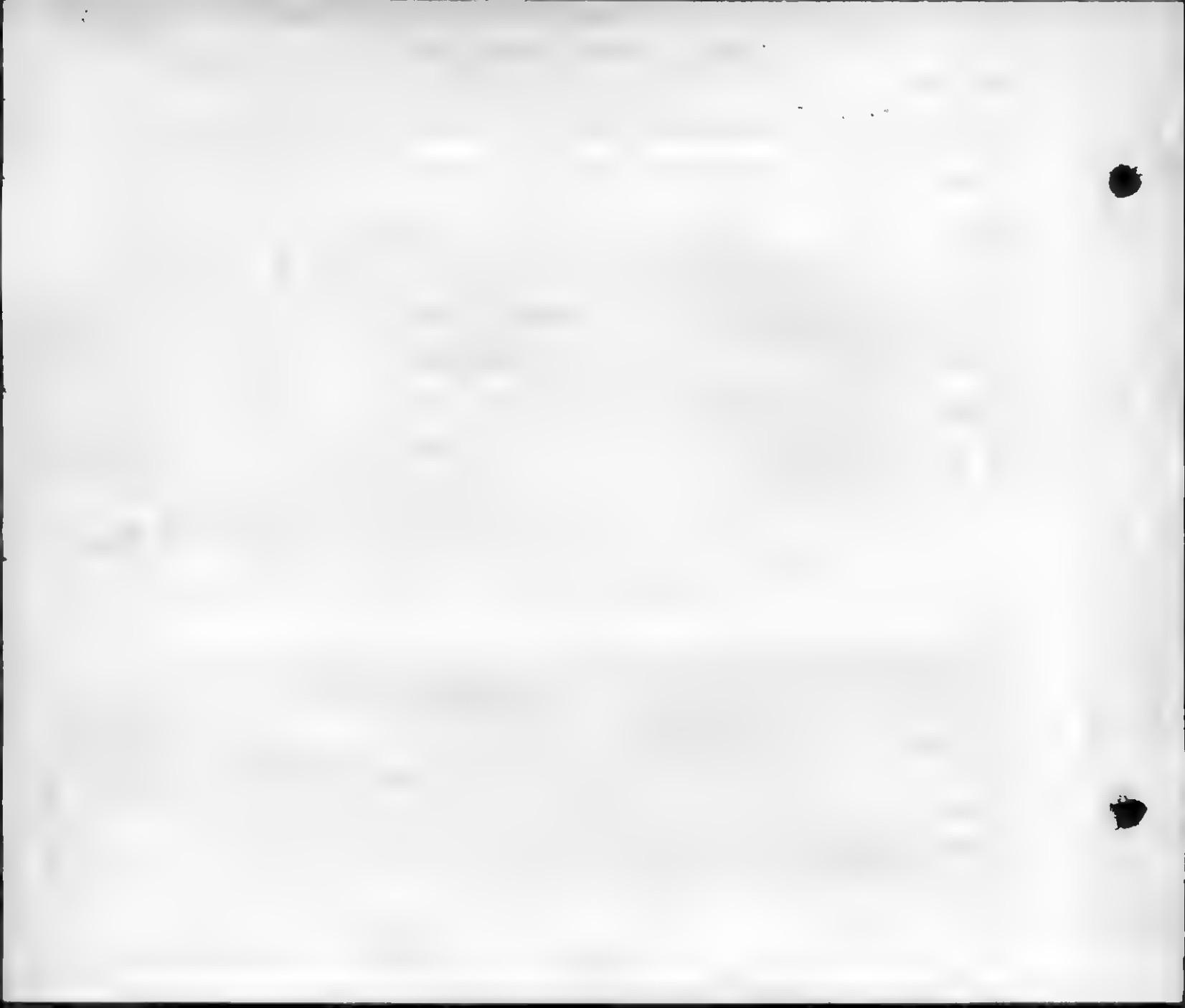
848

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
<i>Bethesda</i>		<i>12 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Suburban</i>		<i>Washington D.C.</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>4228 Fessenden St. N.W.</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Elizabeth J. Garrison</i>		<i>E</i>	<i>lizabeth J. Garrison</i>
4. DATE OF DEATH		Month	Day
		<i>Jan.</i>	<i>18</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>female white</i>			
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
		<i>Sept. 25 1879</i>	<i>99</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Housewife</i>		<i>—</i>	<i>DISTRICT OF COLUMBIA</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
<i>U.S.A.</i>		<i>John G. Miller</i>	
14. MOTHER'S MAIDEN NAME		<i>Elizabeth Burrows</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>none</i>	<i>Karl A. Voigt</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address <i>5214 Tilden Rd.</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>	
<i>Hemiplegia, left, severe</i>		<i>16 year</i>	
DUE TO		<i>10 year</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)		<i>Hypertension, severe</i>	
DUE TO		<i>16 year</i>	
(c)		<i>Alloinfection, generalized</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from <i>Jan 17, 1959</i> , and that death occurred at <i>2:30 A.M.</i> on the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3921 Ingomar St. D.C.</i> DATE SIGNED <i>1/18/59</i>	
ACTUAL SIGNATURE <i>Stewart Clapp</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>		Wash D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/20/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Croiset Hill Cemetery</i>
22d. LOCATION (City, town or county) <i>Washington D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ching Chae Funeral Home</i>		24a. REC'D BY REGISTRAR <i>JAN 21 59</i>	24b. REGISTRAR'S SIGNATURE <i>Ching Chae</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gainesville</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
3. NAME OF DECEASED (Type or print) <i>James C. Gibb</i>		4. STREET ADDRESS <i>19209 Montana DR</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 27 1910</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) <i>48 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. <i>01 16</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Analyst</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
10c. BIRTHPLACE (State or foreign country) <i>China</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
12. FATHER'S NAME <i>John M. Gibb</i>		13. MOTHER'S MAIDEN NAME <i>Candice</i>	
14. SOCIAL SECURITY NO <i>No</i>		15. INFORMANT <i>Frances H. Gibb wife - Sister</i>	
16. ADDRESS		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>coronary Artery Disease</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 26</i> , 1958, to <i>Jan 13</i> , 1959, that I last saw the deceased alive on <i>January 13</i> , 1959, and that death occurred at <i>8:50 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 8016 Old Georgetown Rd., Bethesda, Md.</i>	
ACTUAL SIGNATURE <i>Habib Bacchus</i>		DATE SIGNED <i>1/13/59</i>	
PHYSICIAN'S NAME (Type) <i>HABEEB BACCHUS</i>		8016 Old Georgetown Rd., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1-15-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town or county) (State) <i>Prince George County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY, Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 19 '59	
		24b. REGISTRAR'S SIGNATURE <i>Ernest S. Tisca</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



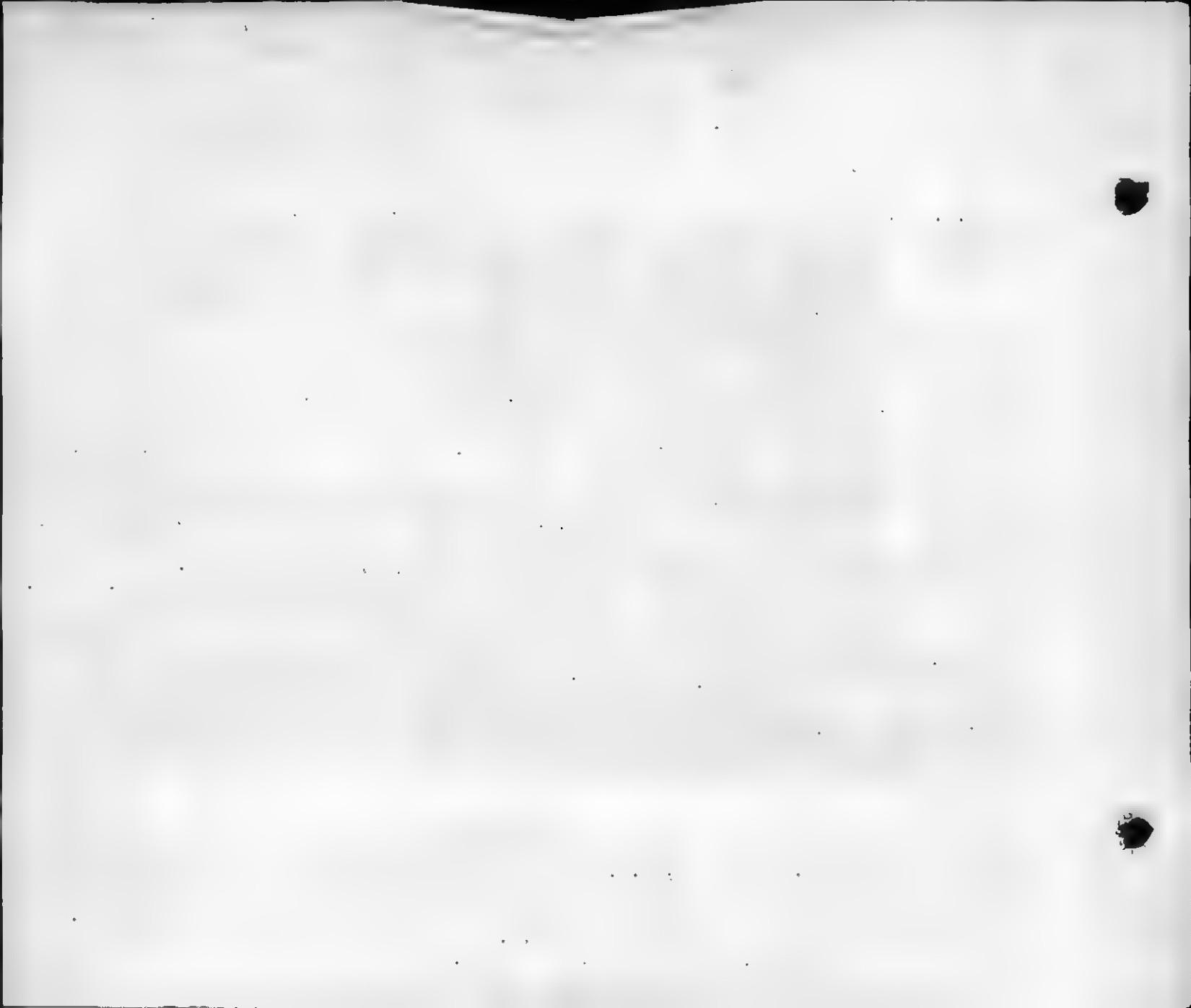
00828

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE
HEALTH DEPT.**

TO DEPUTY
execute the _____
TO FUNERAL DIRECTOR: Please, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be returned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		850 Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)		Reg. Dist. No. 215			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN HB Bethesda 30 Minutes		d. STATE Virginia COUNT Alexandria					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		U.S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Alexandria			
3. NAME OF DECEASED (Type or print)		First Scott	Middle Allan	Last Glickman	f. STREET ADDRESS 506 North Jordan Street	g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1 Sept 1958	8. AGE (In years last b'day) 4mo	9. IF UNDER 1 YEAR Months 4	10. IF UNDER 24 HRS Days 14	11. Month 20	12. Year 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arnold Lawrence Glickman		16. SOCIAL SECURITY NO None		17. INFORMANT Arlynn Bethe Welber		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Fracture, simple, comminuted, depressed, traumatic, stellate, left parietal bone with extension to right, parietal bone and right and left temporal bones.		INTERVAL BETWEEN ONSET AND DEATH Apr. 2 hrs.			
20c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Child was carried by father who tripped and fell.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20f. (City or town) Alexandria		(County) Alexandria		(State) Va.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-15-59					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-59		22c. NAME OF CEMETERY OR CREMATORIUM Wellwood Cemetery		22d. LOCATION (City, town, or county) Pinelawn, Long Island, N.Y. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Danzanski Funeral Home, 3501 14th St., NW, Wash.		ADDRESS D.C.		24a. REC'D BY REGISTRAR JAN 19 1959		24b. REGISTRAR'S SIGNATURE John Danzanski			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, File G-238 2/18/59, c.c.

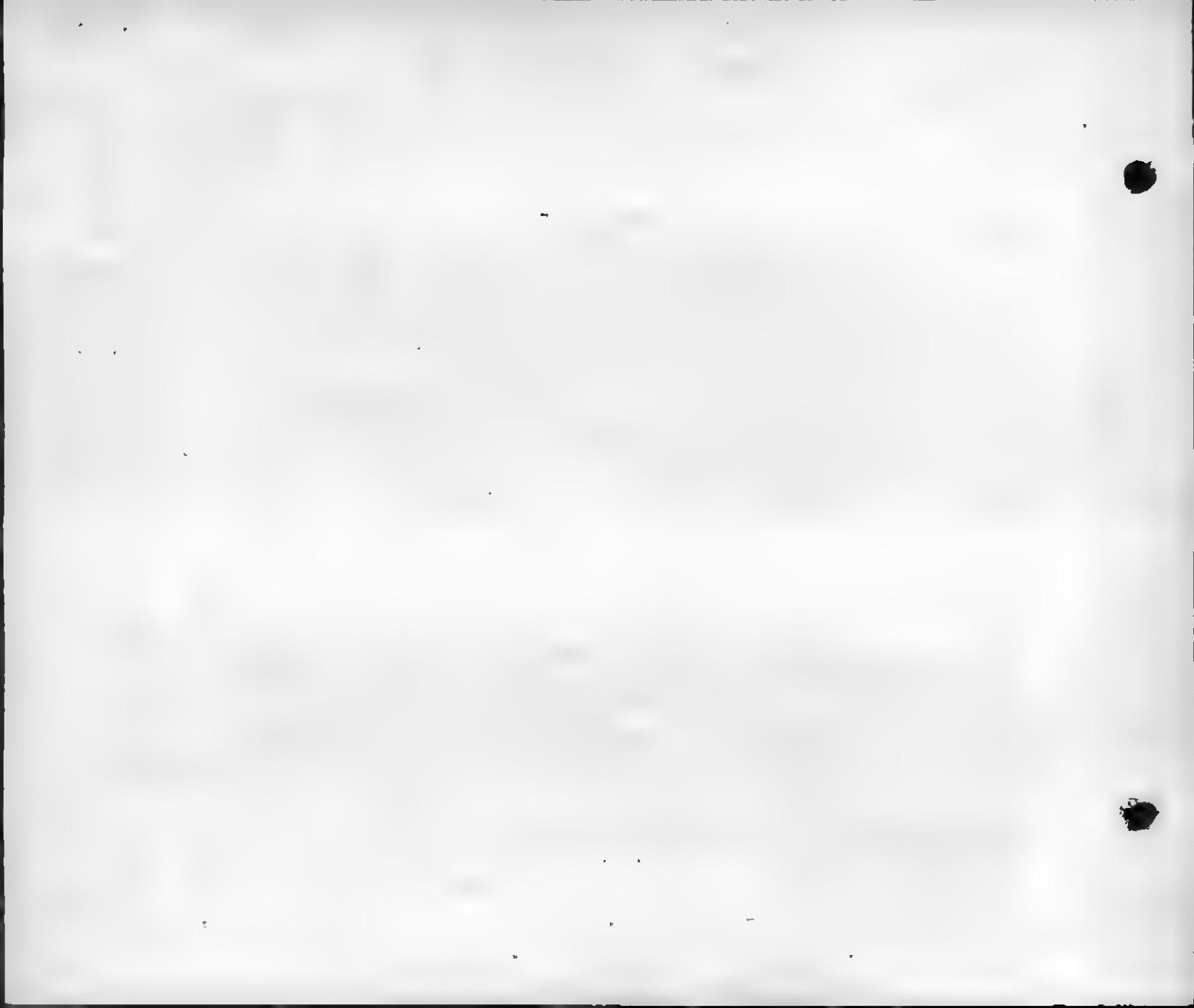
00829

851

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 34 days			b. COUNTY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Pierce					
						d. STREET ADDRESS Route 3, Box 521-E					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) William			First	Middle	Last	4. DATE OF DEATH January 25,	Month	Day	Year 1959		
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH January 26, 1904	10. AGE (In years last b'day) 53 54 yr	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days	13. IF UNDER 24 HRS Hours	14. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Goffred			14. MOTHER'S MAIDEN NAME Mina Suppe								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 152-03-3055			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			274X			INTERVAL BETWEEN ONSET AND DEATH 8 hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			acute myelogenous leukemia			4 mos.					
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 22, 1958, to January 25, 1959, that I last saw the deceased alive on January 25, 1959, and that death occurred at 3:05 PM, from the causes and on the date stated above. MEDICAL CERTIFICATION Signature: James K. Marsh, M. D.									ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - transit 1-27-59			22b. DATE THEREOF Ft. Pierce			22c. NAME OF CEMETERY OR CREMATORIAL Lucie County, Florida			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.			ADDRESS Date Jan 29 '59			24a. REC'D BY REGISTRAR Date Jan 29 '59			24b. REGISTRAR'S SIGNATURE Date Jan 29 '59		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

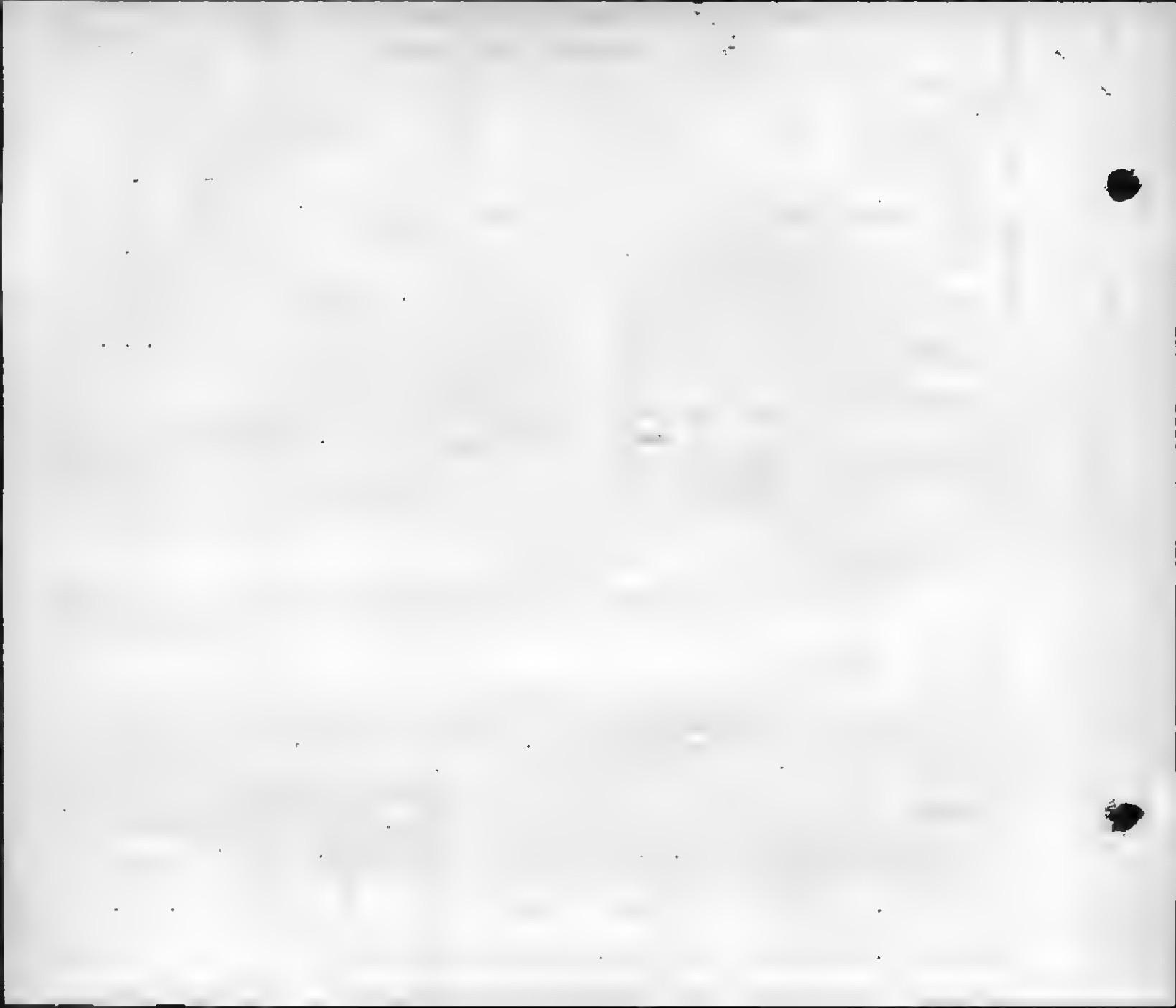
852

CERTIFICATE OF DEATH

00830

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Virginia		If institution, Residence before admission b COUNTY Fairfax				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 90 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McLean						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS Box 32-H LaSalle Avenue, Route #5		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Bertha	Middle Jane	Last Gooding	4. DATE OF DEATH	Month January	Day 20	Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1886	9. AGE (In years lost birthday) 72	IF UNDER 1 YEAR Months 72	IF UNDER 24 HRS Days 0	Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Thomas McCue				14. MOTHER'S MAIDEN NAME Elizabeth Neel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Item no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 234-09-47680		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kycosis Fungoides with Lymphomatous Infiltrates DUE TO in Skin, Liver, Kidneys, and Lymph Nodes				INTERVAL BETWEEN ONSET AND DEATH Years						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 22, 1958 , to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	DATE SIGNED 1-21-59	
ACTUAL SIGNATURE <i>Leonard Garren</i>	M.D.									
PHYSICIAN'S NAME (Type) Leonard Garren, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Tran.	22b. DATE THEREOF 1/26/59	22c. NAME OF CEMETERY OR CREMATORIUM Benedum Cemetery		22d. LOCATION (City, town, or county) Bridgeport, W. Va.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 23 '59	24b. REGISTRAR'S SIGNATURE On Jan 23 '59					
VS A15 (4) 15M 9/55										



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00831

853

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond		First (none)	Middle GOODMAN
4. DATE OF DEATH January 10 1959	Month January	Day 10	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-94
9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY Washington, D. C. U. S. A.	10. BIRTHPLACE (State or foreign country) Washington, D. C.
13. FATHER'S NAME Henry GOODMAN	14. MOTHER'S MAIDEN NAME Jennie NORDLINGER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes WWI	
16. SOCIAL SECURITY NO. Address	17. INFORMANT Official Navy Records	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest INTERVAL BETWEEN ONSET AND DEATH 48 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO CNS Chayia		DUE TO (c) Diabetes mellitus, ASHD - Decompensation INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from January 7, 1959 to January 10, 1959 , that I last saw the deceased alive on January 10, 1959 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE C. U. Shilling ADDRESS (Street, city or town, state) M.D. U. S. Naval Hospital, NNMC DATE SIGNED 1-10-59			
22a. PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN		22b. PLACE OF DEATH Bethesda 14, Maryland	
22c. BURIAL CREMATION, REMOVAL (Specify) Burial	22d. DATE THEREOF 1-13-59	22e. NAME OF CEMETERY OR CREMATORIUM Arlington National	22f. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Penna. Ave., NW, Wash. DC		24a. ADDRESS Jos. Gawler's & Sons, 1756 Penna. Ave., NW, Wash. DC	24b. REC'D BY REGISTRAR DATE JAN 13 '59
		24c. REGISTRAR'S SIGNATURE Walter L. Trahan	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

854

CERTIFICATE OF DEATH

00832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 McNEILL ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) HARRY		First DELAFIELD	Middle GRIMES
4. DATE OF DEATH JAN. 16 1959		Last	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/79
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
12. CITIZEN OF WHAT COUNTRY U.S.A.		Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME GEORGE GRIMES		14. MOTHER'S MAIDEN NAME ANNIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 214-05-7350	17. INFORMANT Mrs. James W. Vandegrift, 613 McNeill Road Address Silver Spring, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Jan. 15 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 15, 1959 , to Jan. 16, 1959 , that I last saw the deceased alive on Jan. 15, 1959 , and that death occurred at 5:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 134 Highland St. Silver Spring, Md.			
ACTUAL SIGNATURE Lewis A. Klein		DATE SIGNED Jan. 16, 1959	
PHYSICIAN'S NAME (Type) LEWIS A. KLEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 1/16/59		22b. DATE THEREOF 1/16/59	22c. NAME OF CEMETERY OR CREMATORIUM Rosehill Cemetery
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D. BY REGISTRAR DATE JAN 19 1959	24b. REGISTRAR'S SIGNATURE L. S. Davis
Raymond A. Klein		ADDRESS SILVER SPRING, MD.	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00833

855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a. STATE <u>MD</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN lb <u>6 mo</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1200 Tanley Rd</u>		d. STREET ADDRESS <u>1200 Tanley Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Walter</u>		4. DATE OF DEATH <u>1 - 4 - 1959</u>	
First <u>Charles</u> Middle <u>Hagerton</u>		Month <u>1</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-97</u>	
9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Navy Bureau Yards & Docks</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical eng.</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hagerton</u>	
14. MOTHER'S MAIDEN NAME <u>Ryan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> YES <u>WW # 1</u>	
16. SOCIAL SECURITY NO <u>031-07-7821</u>		17. INFORMANT <u>Jane Ryan (daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>✓</u>	
DUE TO (b) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		20. INTERVAL BETWEEN ONSET AND DEATH <u>XXXXXX</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hunting & strenuous heart disease</u>		21. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>✓</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u>While at work</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>(County)</u> <u>(State)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>1-4-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Bista</u>		24b. REGISTRAR'S SIGNATURE <u>1-4-59</u>	
VS. A15ME BM 2/57			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4
855

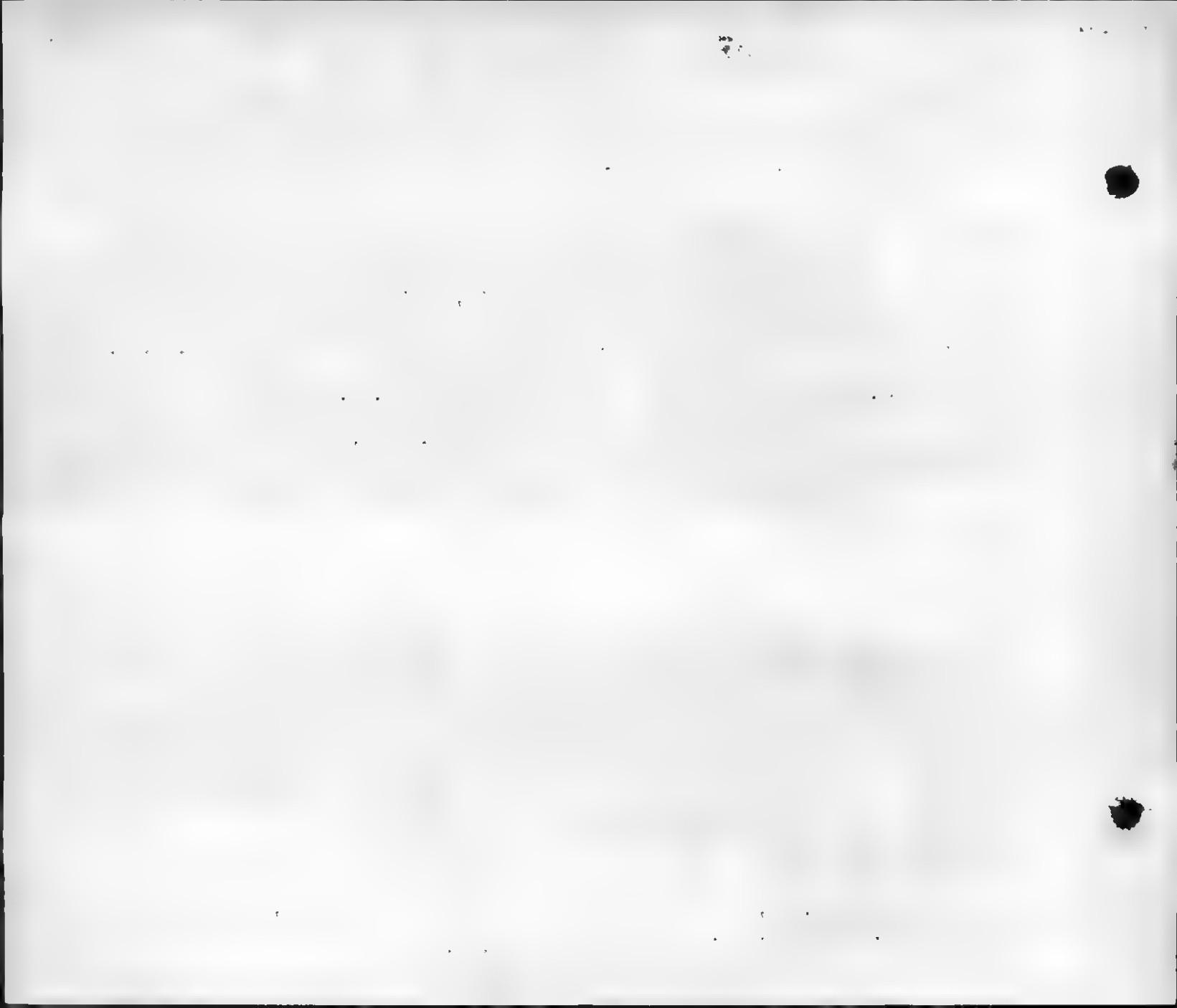
CERTIFICATE OF DEATH

100834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 15 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 619 GREENBRIAR DRIVE		d. STREET ADDRESS 619 GREENBRIAR DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First MARY	Middle VERONICA	Last HALL	4 DATE OF DEATH	Month JANUARY	Day 22	Year 1959
5. SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 25, 1887	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CO-OWNER		10b. KIND OF BUSINESS OR INDUSTRY INFANT'S CLOTHING STORE		11. BIRTHPLACE (State or foreign country) ENGLAND		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS J. HALL		14. MOTHER'S MAIDEN NAME CATHERINE M. T. LALLY		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MISS ELLEN E. HALL, 619 GREENBRIAR DRIVE					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Cardiac Failure</i>				INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Myo Cardial Degeneration</i>				2 years	
DUE TO (b)		<i>Generalized arterio-Sclerosis</i>					
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]					
20c. TIME OF INJURY Hour o m p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Nov 10, 1957</u> , to <u>Jan 22, 1959</u> , that I last saw the deceased alive on <u>Jan 21, 1959</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>8248 Georgia Ave</u>				DATE SIGNED <u>1/22/59</u>	
ACTUAL SIGNATURE <u>Merrill M. Cross</u>	M.D. <u>8248 Georgia Ave</u>						
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>	Silver Spring, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 26, 1959	22c. NAME OF CEMETERY OR CREMATORIUM SACRED HEART CEMETERY	22d. LOCATION (City, town, or county) VINELAND, NEW JERSEY	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.	ADDRESS <u>Raymond A. Zajicek</u>	24a. REC'D BY REGISTRAR JAN 26 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hayes</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00835

857

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Petworth</i>	c. LENGTH OF STAY IN 1b <i>1/2 day</i>	b. COUNTY <i>Maryland</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburbans</i>	e. STREET ADDRESS <i>—</i>	d. STREET ADDRESS <i>—</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Badger</i>	First <i>Murry</i>	Middle <i>Holloman</i>	Last <i>—</i>	4. DATE OF DEATH <i>1/18/59</i>	Month <i>1</i>	Day <i>18</i>	Year <i>59</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/5/93</i>	9. AGE (In years last birthday) <i>65</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS Days <i>—</i>	12. IF UNDER 24 HRS Hours <i>—</i>	13. IF UNDER 24 HRS Min <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Messenger</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>	10c. BIRTHPLACE (State or foreign country) <i>Rockville, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>John Henry Holloman</i>	14. MOTHER'S MAIDEN NAME <i>Mary Ellen Davis</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>578-03-1234</i>	17. INFORMANT <i>John O. Radler, 7930 Georgia Avenue, Md.</i>	Address <i>—</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Never percedium</i> DUE TO <i>Stomachic</i> INTERVAL BETWEEN ONSET AND DEATH <i>1-1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>451X</i> (b) <i>Disseching aortic aneurysm</i> (c) <i>Dissection of aortic aneurysm</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>1-17-59</i> to <i>1-18-59</i> , that I last saw the deceased alive on <i>1-18-59</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>John O. Radler, 7930 Georgia Avenue, Md.</i> DATE SIGNED <i>John O. Radler</i>								
ACTUAL SIGNATURE <i>John O. Radler</i>		PHYSICIAN'S NAME (Type) <i>Elijah</i>						
22a. BURIAL, CREMATION, REMAINS (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/23/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Elijah</i>		22d. LOCATION (City, town, or county) (State) <i>Poolesville, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 21 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Klaus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A

B

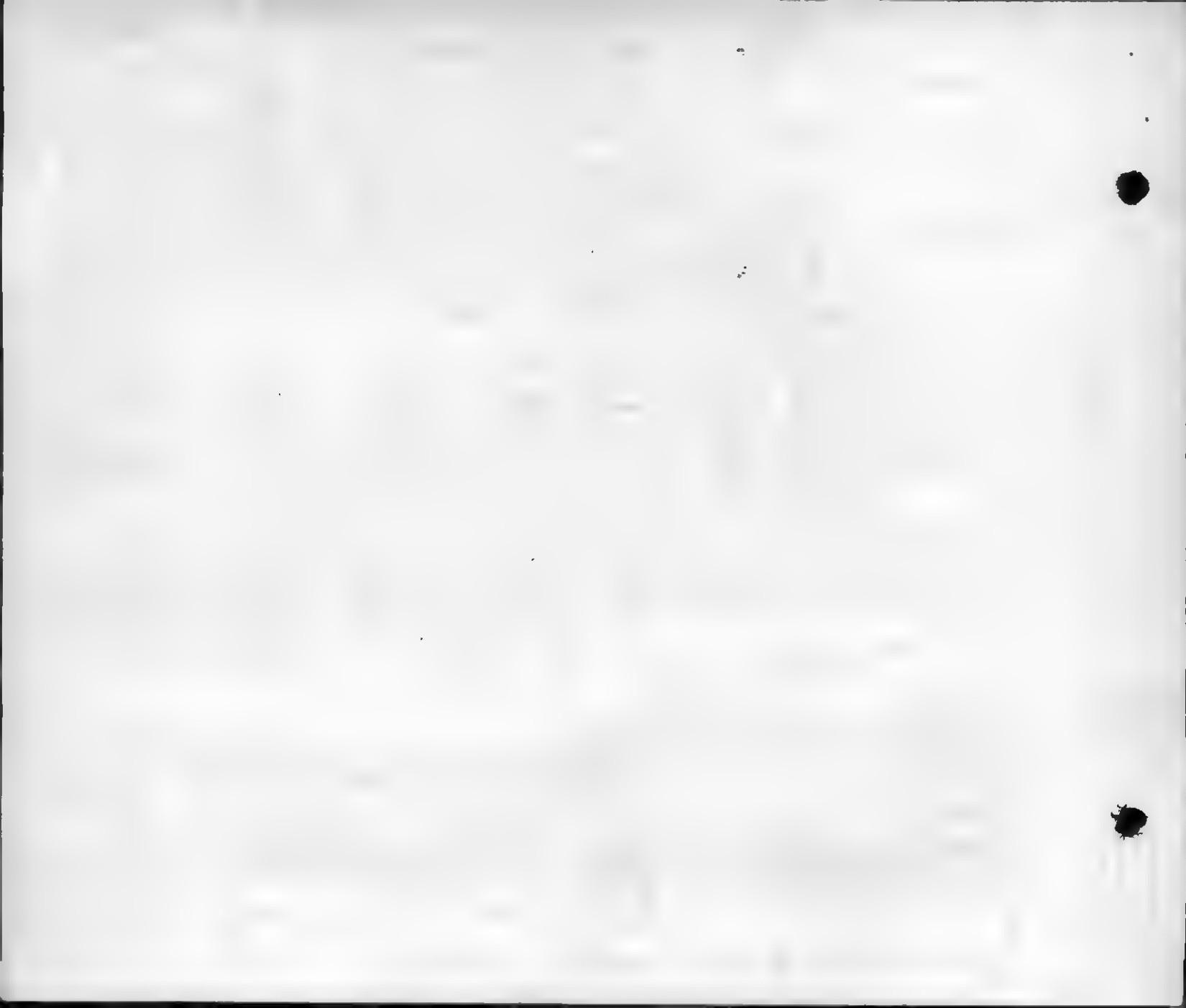
C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
767 Item 2 Film G238 1-30-53 et
CERTIFICATE OF DEATH

00836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery Takoma Park		a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 166 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellen Mary Hamer		4. STREET ADDRESS 1401 Montana Ave. N.E.	
5. SEX Female		5. COLOR OR RACE White	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH 11-29-67	
8. AGE (In years lost birthday) 91 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Patrick Ruane		14. MOTHER'S MAIDEN NAME Ellen McDaniel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Anemia (c) Hemorrhage From Duodenal Ulcer		INTERVAL BETWEEN ONSET AND DEATH 4 days 8 days? 8 days?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Spring</u> , 19 <u>58</u> , to <u>Jan 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>59</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 7720 Wisconsin Ave., Bethesda, Md.	
ACTUAL SIGNATURE James W. Egan		DATE SIGNED	
PHYSICIAN'S NAME (Type) JAMES W. EGAN		SAME	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Jan 8, 1959	
22c. NAME OF CEMETERY, OR CREMATORIAL St. Louis Ph's		22d. LOCATION (City, town, or county) Hammond, Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chappell Co 1400 Chaplin St NW		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
ADDRESS Wash. D.C.		24b. REGISTRAR'S SIGNATURE C. Smith & Sons	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

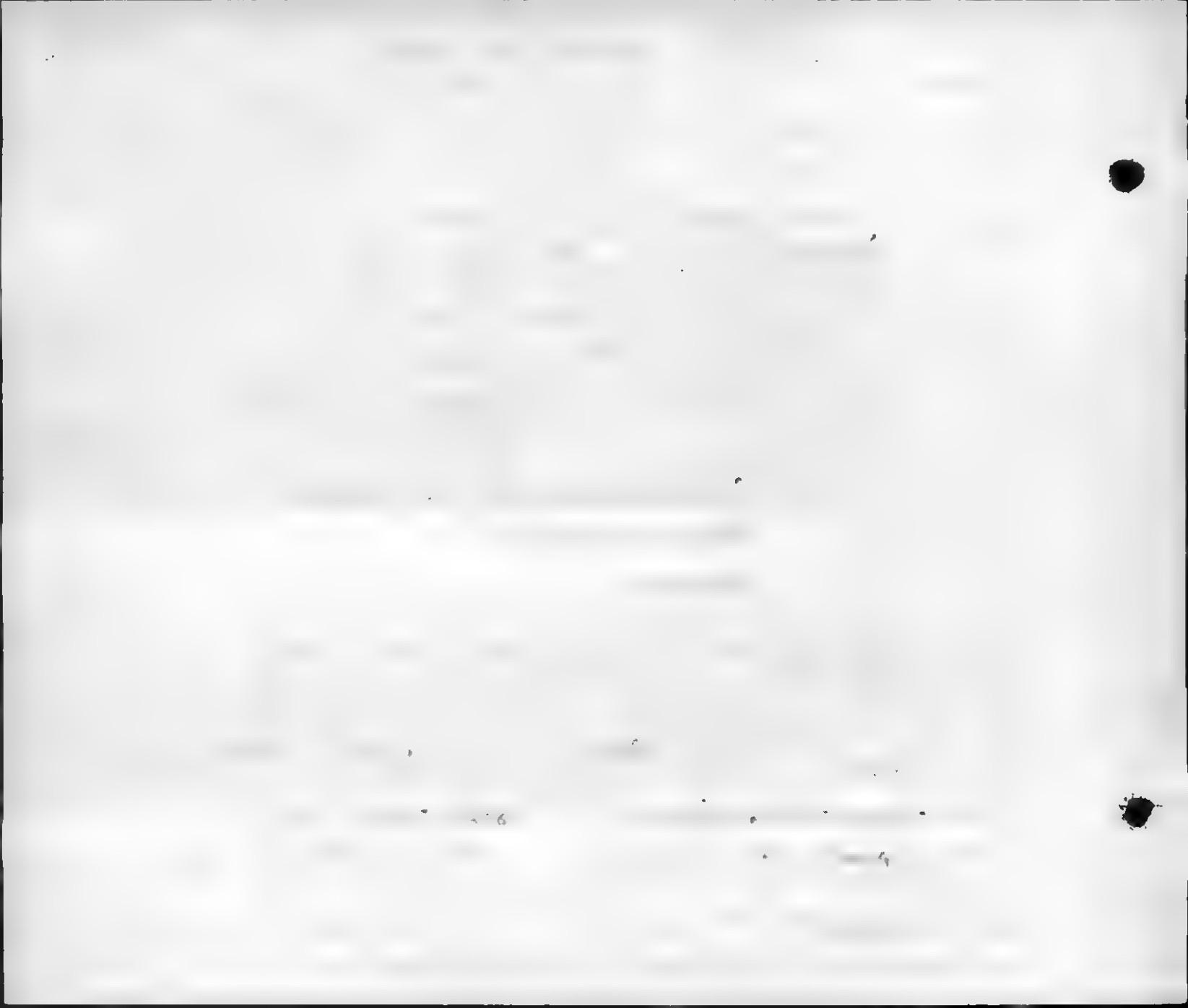
858

CERTIFICATE OF DEATH

00837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b RURAL	b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAKHAVEN REST HOME	d. STREET ADDRESS 5923 4th St NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ALBERT L. HANCOCK	First	Middle	Last
4. DATE OF DEATH Jan 28	Month	Day	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 11, 1876
9. AGE (in years (last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspector Fire Dept	10b. KIND OF BUSINESS OR INDUSTRY Fire Dept	11. BIRTHPLACE (State or foreign country) 2nd	12. CITIZEN OF WHAT COUNTRY? Katie I Hancock 5923 4th St NW
13. FATHER'S NAME Thomas Hancock	14. MOTHER'S MAIDEN NAME Marie Richards		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Katie I Hancock 5923 4th St NW	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR HEMORRHAGE			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. ARTERIOSCLEROSIS			
DUE TO SENILITY			
INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 , to 1-28-1959 , that I last saw the deceased alive on 1-27-1959 , and that death occurred at 12:00 M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel A. Hillman			ADDRESS (Street, city or town, state) 8829 Flower Ave
PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN			DATE SIGNED 1-28-59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Southland Md
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home 4812 36th Avenue		ADDRESS Deaf Funeral Home 4812 36th Avenue	24a. REC'D BY REGISTRAR DATE FEB 2 '59
			24b. REGISTRAR'S SIGNATURE 1-28-59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00838

859

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>10 min.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>		d. STREET ADDRESS <i>5604 Wisconsin Ave.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Ernest</i>		First <i>E</i>	Middle <i>Clyde</i>	Last <i>Harned</i>	4. DATE OF DEATH <i>1/19/59</i>	Month <i>1</i>	Day <i>19</i>	Year <i>1959</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 12 1886</i>	9. AGE (In years lost birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>4</i>	Days <i>7</i>	Hours <i>0</i>	Min <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Isaac Harned</i>		14. MOTHER'S MAIDEN NAME <i>ANNA Shade</i>		Address <i>mt. 577-30-3136 Estella Harned, 5604 Wisconsin Ave Chevy Chase</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-30-3136</i>		17. INFORMANT <i>Estella Harned, 5604 Wisconsin Ave Chevy Chase</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Angina Pectoris</i>				INTERVAL BETWEEN ONSET AND DEATH <i>45 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>	
21. I certify that I attended the deceased from <i>Dec 26, 1958</i> , to <i>Jan 30, 1958</i> , that I last saw the deceased alive on <i>Dec 26, 1958</i> , and that death occurred at <i>11:15 PM</i> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) <i>4413 Bradley Lane, Bethesda, Md.</i>											
DATE SIGNED <i>1/21/59</i>											
ACTUAL SIGNATURE <i>Bradley D. Hodgkins M.D.</i>		4413 Bradley Lane, Bethesda, Md.									
PHYSICIAN'S NAME (Type) <i>Bradley D. Hodgkins</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Nat. Memorial Cem.</i>		22d. LOCATION (City, town, or county) <i>Falls Church, Virginia</i>		(State) <i></i>					
22e. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>1/23/59</i>		24a. REC'D BY REGISTRAR <i>JAN 21 59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		DATE <i>JAN 21 59</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00839

860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #1700# Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) b. INSTITUTION Belmont Nursing Home		d. STREET ADDRESS 1700 Marymont Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eugene	Middle Harriss	4. DATE OF DEATH Jan. 17 Month Day Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1876
9. AGE (in years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Henery Harriss		14. MOTHER'S MAIDEN NAME Eliza Virginia Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT William W. Evans		Address Same As	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation, thrombosis DUE TO 552X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cereological arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Sandy Spring (State) Md.	
21. I certify that I attended the deceased from Jan 12 1959 to Jan 17 1959 , that I last saw the deceased alive on Jan 12 1959 , and that death occurred at Sandy Spring, Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Boyce M.D. Sandy Spring, Md. 1/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19 1959	
22c. NAME OF CEMETERY OR CREMATORIUM St. Johns		22d. LOCATION (City, town, or county) Olney (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. W. Barber		24a. REC'D BY REGISTRAR DATE JAN 20 59	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Robert L. Knudsen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

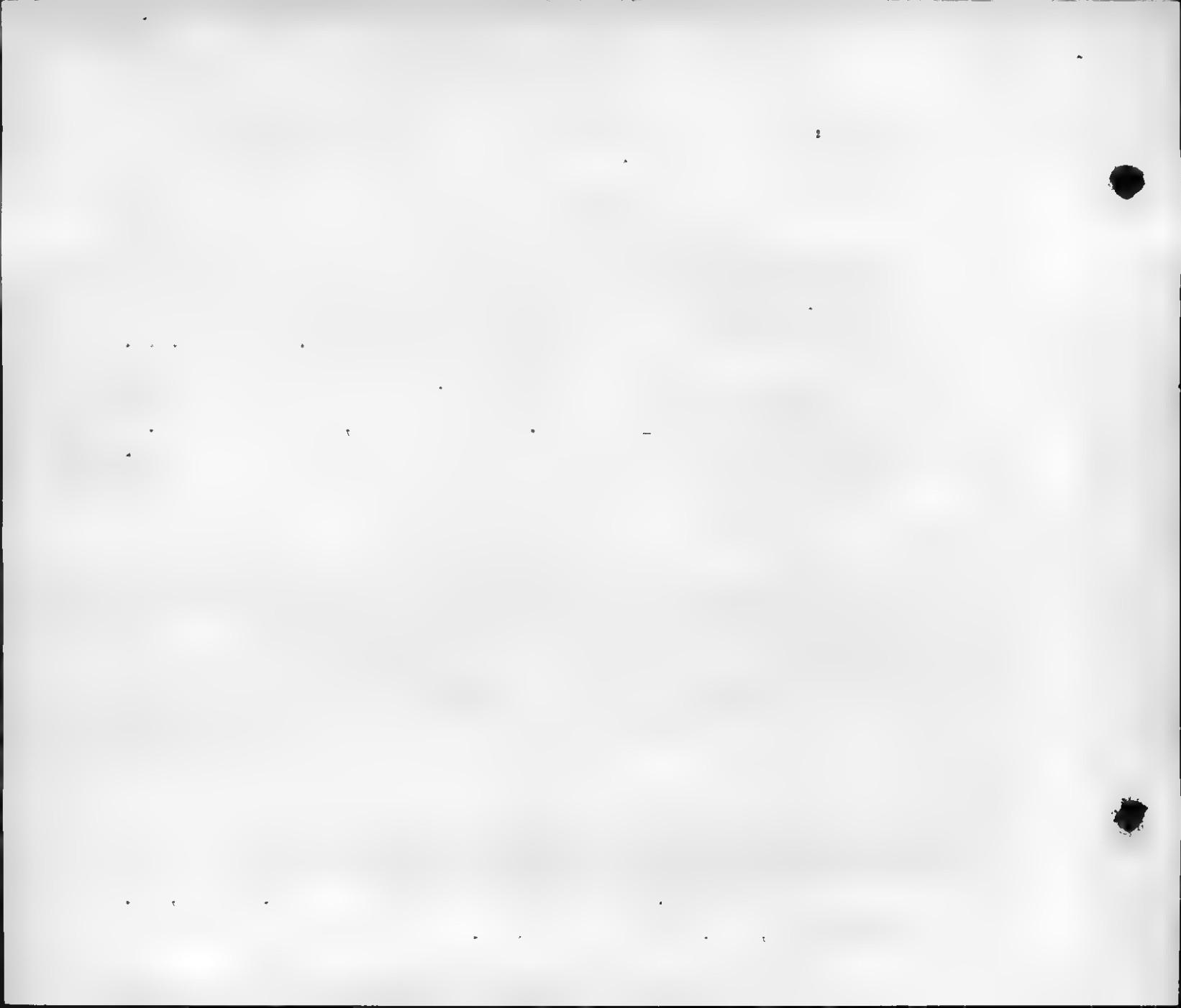
861

CERTIFICATE OF DEATH

00840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 705 Ritchie Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle B	Last HARVEY		
4. DATE OF DEATH	Month JANUARY	Day 10	Year 19 59		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/74		
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse (retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Silver Spring, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN BAILEY CLARK	14. MOTHER'S MAIDEN NAME EMMA A. HARDISTY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO	16. SOCIAL SECURITY NO 578-01-0924	17. INFORMANT Mrs. Katherine Lorz, 705 Ritchie Ave.	Address Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —				
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from July 10, 1954 , to Jan 10, 1959 , that I last saw the deceased alive on Jan 10, 1959 , and that death occurred at 10SP , M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Ralph F. Patten</i>	PHYSICIAN'S NAME (Type) RALPH F. PATTEN		ADDRESS (Street, city or town, state) 8641 - Colesville Road Jan 10, 55	DATE SIGNED Jan 10, 55	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/13/59	22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE RAYMOND A. ZEITZ	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR JAN 13 1959	24b. REGISTRAR'S SIGNATURE L. Frank		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

768

CERTIFICATE OF DEATH

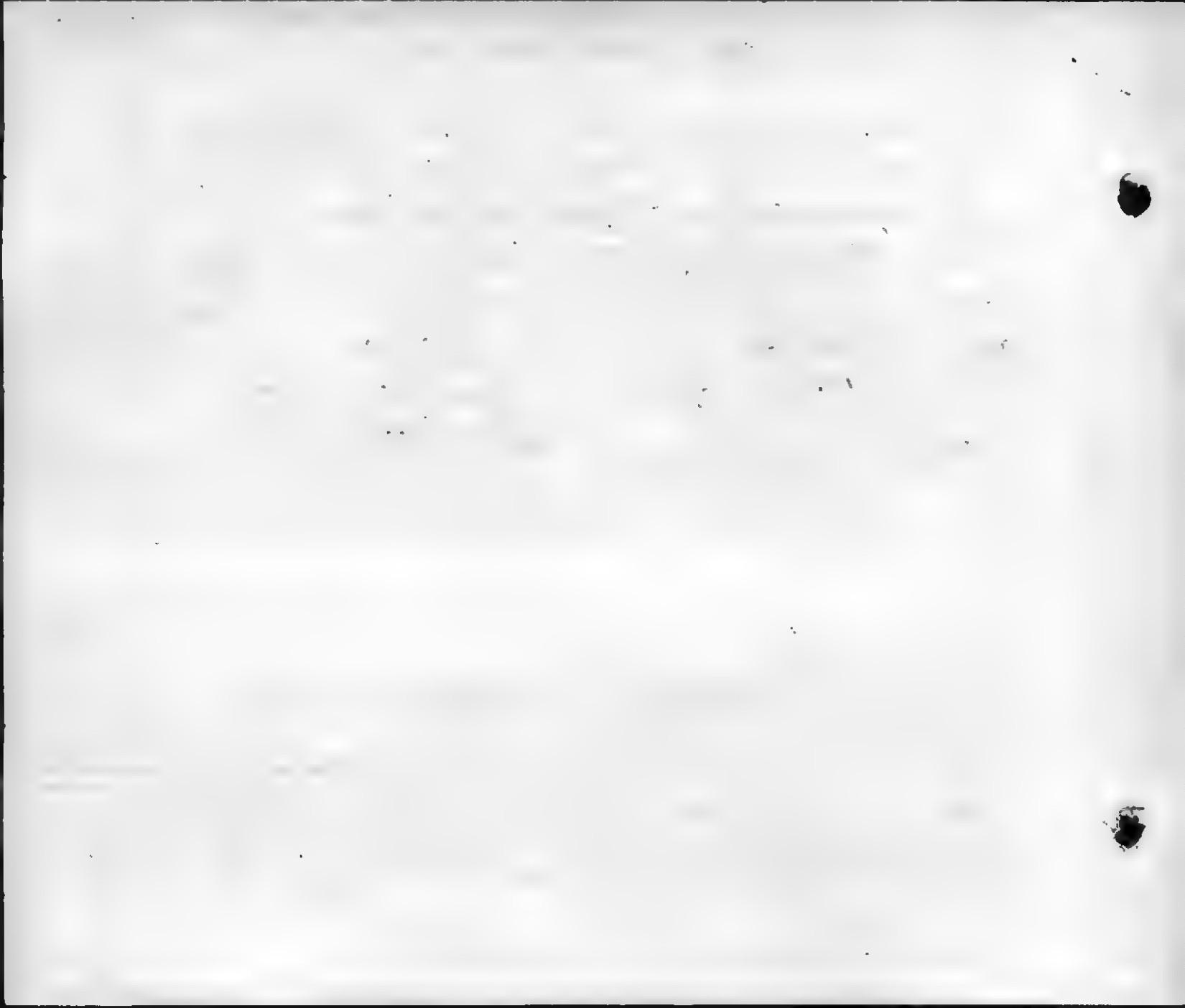
06841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>12 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. STREET ADDRESS <i>3606 Warwick Pl.</i>	
3. NAME OF DECEASED (Type or print) <i>Marion Hawthorne Hedges</i>		4. DATE OF DEATH <i>January 6 1959</i>	* IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-14-88</i>
9. AGE (in years (last birthday) <i>70 yrs.</i>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <i>3</i> Days <i>12</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreign Operations Adm. U.S. Govt</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Indiana</i>	
13. FATHER'S NAME <i>Thomas Benton Hedges</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Mullen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>CORONARY SCLEROSIS</i> DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i> YEARS		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>MONTHS</i> <i>YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (6) (1) <i>DUODENAL Peptic Ulcer</i> (2) <i>DIABETES MELLITUS</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 6, 1959</i> to <i>Jan 6, 1959</i> , that I last saw the deceased alive on <i>Jan 5, 1959</i> , and that death occurred at <i>8:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Brinklow, Maryland</i> DATE SIGNED <i>1/6/59</i>			
ACTUAL SIGNATURE <i>Seruch T. Kimble</i>		M.D. <i>229 Pershing Dr. Silver Spring, Md</i>	
PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble</i>		22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 1/9/59	
22c. DATE THEREOF <i>1/9/59</i>		22d. NAME OF CEMETERY OR CREMATORIUM <i>Woodside</i>	
22e. LOCATION (City, town, or county) <i>Brinklow, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
		24a. REC'D BY REGISTRAR <i>Jan 12 '59</i>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

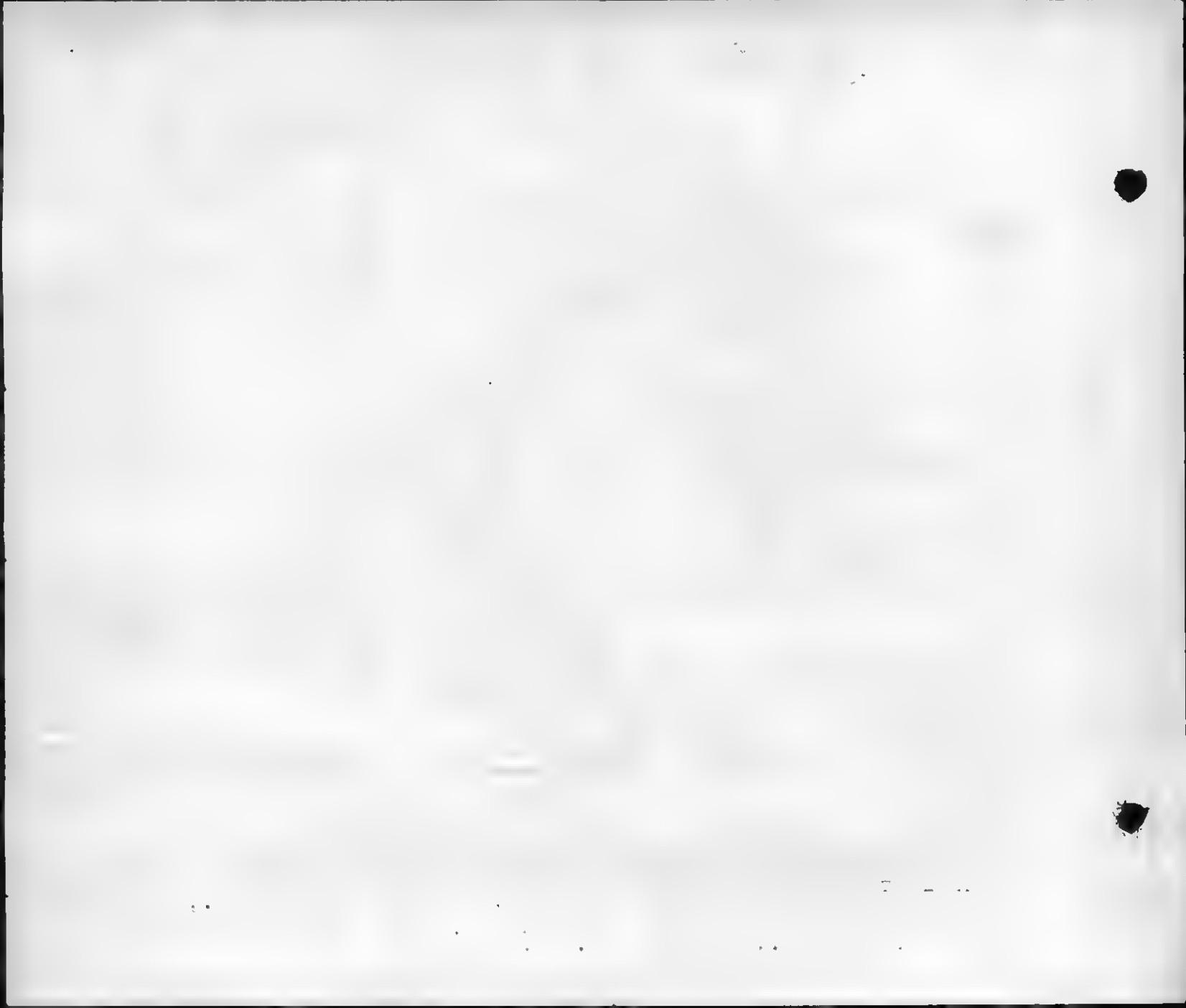
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MONTGOMERY</i>		c. LENGTH OF STAY IN lb <i>4 YEARS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>FRANKLIN BILLY AIR.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MONTGOMERY</i>			
f. STREET ADDRESS <i>FRANKLIN BILLY AIR.</i>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF (Type or print)	First <i>ANDREA</i>	Middle <i>MARIA</i>	Last <i>HEINTZ</i>		
4. DATE OF DEATH Month <i>JAN.</i>	Day <i>24</i>	Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 7, 1877</i>		
9. AGE (in years lost birthday) yrs. Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>~</i>	11. BIRTHPLACE (State or foreign country) <i>NAZARETH, POLAND</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>EDWARD JAPORSKY</i>	14. MOTHER'S MAIDEN NAME <i>MARIA TAFORSKA</i>	Address <i>SIXTY EIGHT HENRY, AS ABOVE</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. <i>88</i>	17. INFORMANT <i>SON OF CAR HEINTZ, AS ABOVE</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHITIS, CYSTOMA, TERMINAL</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <i>173X</i>	X Part II (b) DUE TO (c) <i>Fracture of the right femur</i>	INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	19. DATE <i>1-16-59</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>January 19, 1959</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> or work <input type="checkbox"/> <i>5:45 P.M.</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>FRANK S. HINES, M.D.</i>	20f. (City or town) <i>Montgomery Co., Maryland</i>	(County) <i>Montgomery Co.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>1953</i> to <i>1959</i> , that I last saw the deceased alive on <i>JAN 24, 1959</i> , and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>FRANK S. HINES, M.D.</i>	ADDRESS (Street, city or town, state) <i>1811 E ST N.W., WASHINGTON, D.C.</i>			DATE SIGNED <i>1-27-59</i>	
PHYSICIAN'S NAME (Type) <i>FRANK S. HINES, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL OR TRANSIT burial	22b. DATE THEREOF <i>1/27/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>GATE OF HEAVEN</i>	22d. LOCATION (City, town, or county) <i>Montgomery Co., Maryland</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.,</i>	ADDRESS <i>Wash., D.C.</i>	24a. REC'D BY REGISTRAR DATE JAN 27 '59	24b. REGISTRAR'S SIGNATURE <i>C. H. Frank</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

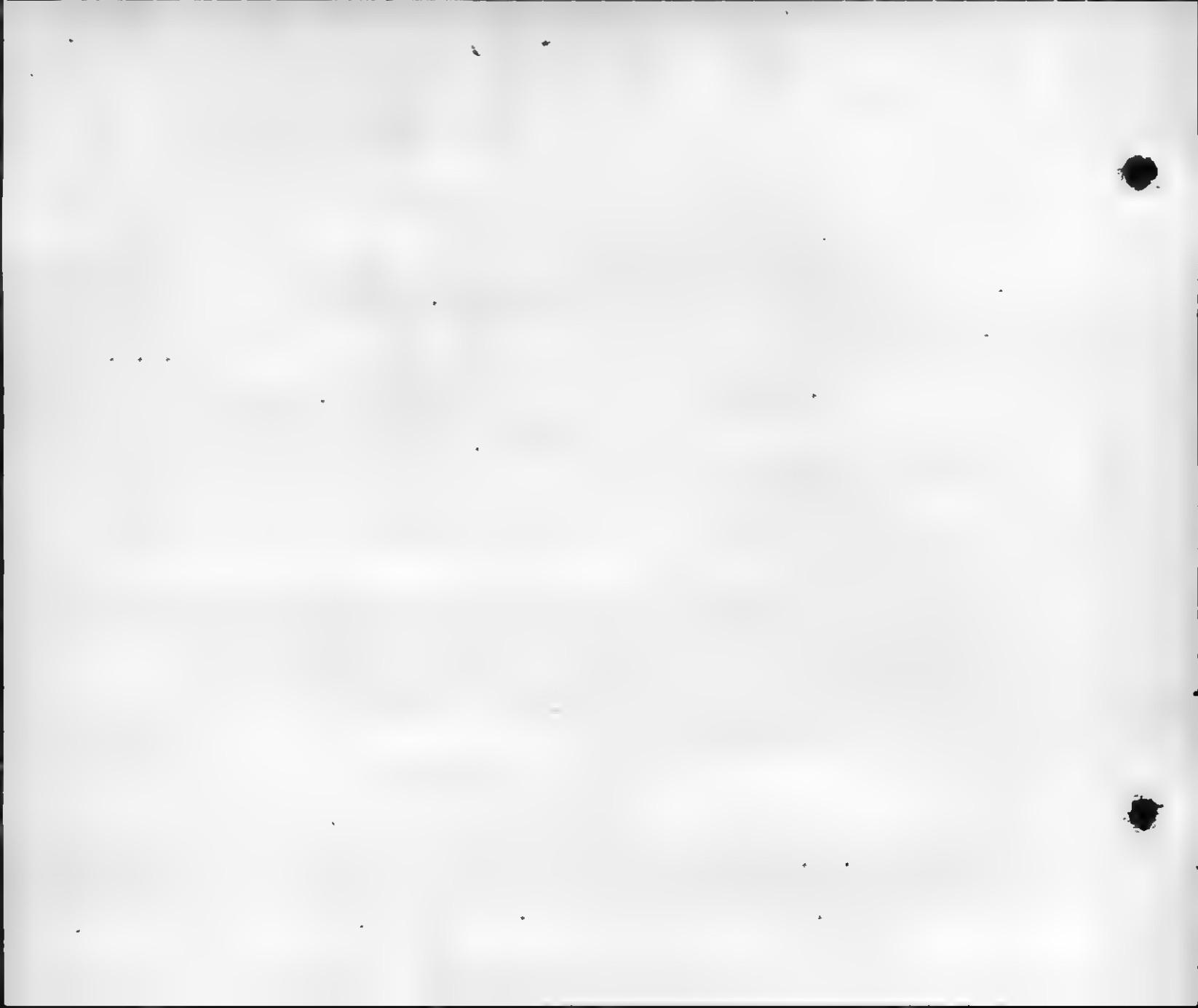
00843

863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] RURAL Oiney		c. LENGTH OF STAY IN lb 50 years		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] X Oiney				
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Amy		First	Middle Florence	Last Hett	4. DATE OF DEATH	Month JANUARY	Day 15	Year 19 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Feb. 1879		9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Carlton E. Bland		14. MOTHER'S MAIDEN NAME Margaret A. Craver				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT John D. Hett		Same As 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteria</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> 599X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Nephritis & Thetitis</i> AGE AT DEATH <i>4 years</i> (b) DUE TO (c) DUE TO (d) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1971</i> , 19 59, to <i>17/15</i> , 19 59, that I last saw the deceased alive on <i>1/13/59</i> , 19 59, and that death occurred at <i>10:04 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. W. Bird</i> ADDRESS (Street, city or town, state) <i>Sandy Spring</i> DATE SIGNED <i>1/17/59</i>								
PHYSICIAN'S NAME (Type) J. W. Bird		Sandy Spring		Md.				
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF Jan. 18 1959		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>May W. Barber</i>		ADDRESS <i>Laytonsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Henry S. Kraus</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00845

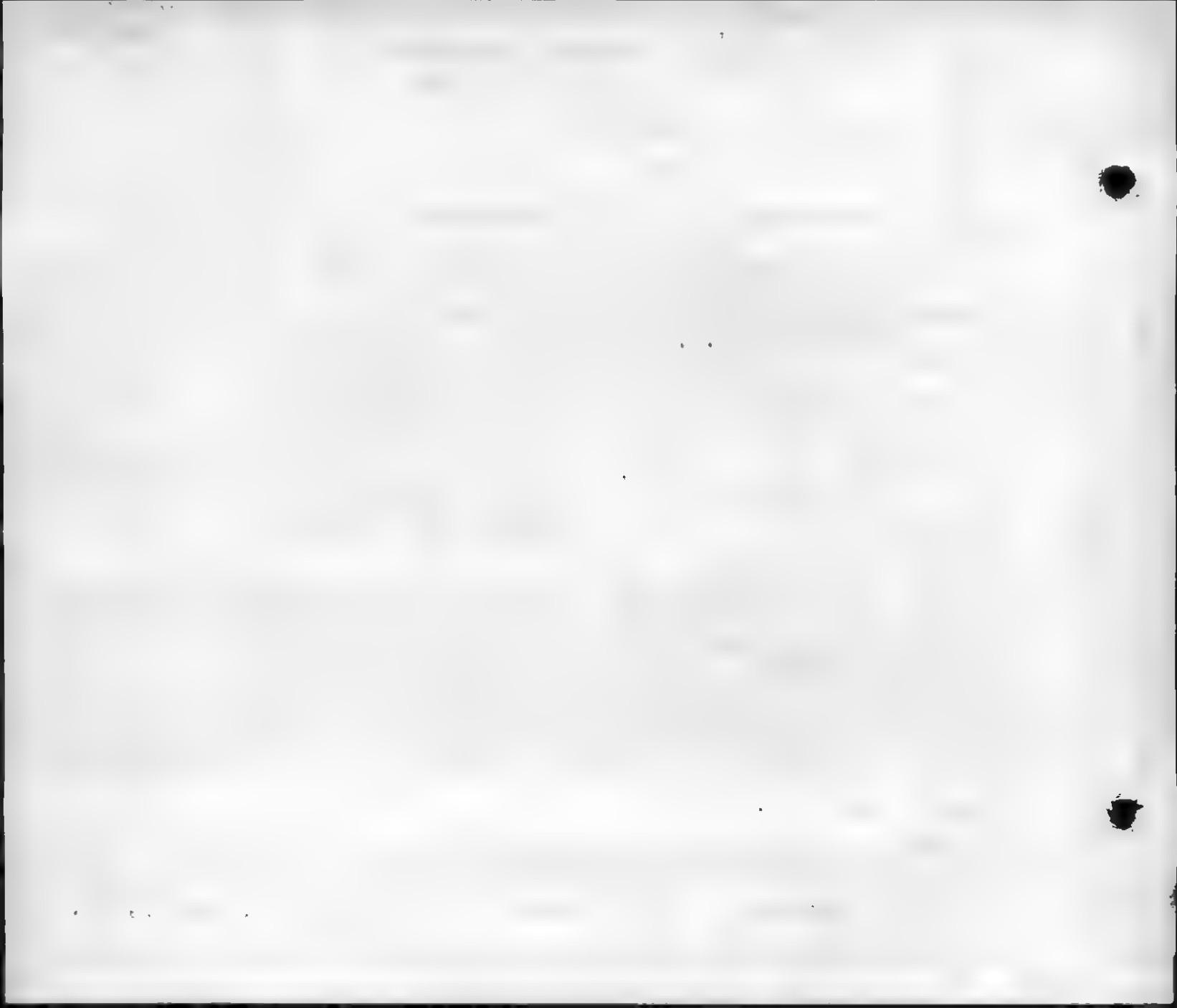
864

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY	
c LENGTH OF STAY IN 1b <i>13 days & 18 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d STREET ADDRESS 1456 Clifton St N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Harry	Middle M	Last Hitchcock
4. DATE OF DEATH	Month Jan	Day 23	Year 1959
5. SEX	6 COLOR OR RACE M	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/92
	W WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Henry Hitchcock	14. MOTHER'S MAIDEN NAME Mary Ann Reed		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes Army	16. SOCIAL SECURITY NO. None	17. INFORMANT Son (Wallace Hitchcock)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>Anteriorclastic Heart Disease</i> DUE TO (c) <i>Diabetic Melitus</i>			INTERVAL BETWEEN ONSET AND DEATH 62yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 to 1959, that I last saw the deceased alive on 6-22-1959, and that death occurred at 7:40 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph A. Bailey</i>	M.D.	ADDRESS (Street, city or town, state) <i>Wash. Drive, Wash. D.C.</i>	DATE SIGNED
PHYSICIAN'S NAME (Type) <i>JOSEPH A. BAILEY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>1/26/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>	22d LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.H. Hines Co. by J.W. Edwards 2901 14th St. N.W.</i>	ADDRESS <i>Wash. D.C.</i>	24a. REC'D BY REGISTRAR <i>JAN 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>G. E. L. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

865

CERTIFICATE OF DEATH

00846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 7 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital	d. STREET ADDRESS 6029 Grosvenor Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Ella Last Hogland	4. DATE OF DEATH January 26, 1959		Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1914
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 11 Days 6 Hours 0 Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hugh P. Brown		14. MOTHER'S MAIDEN NAME Naomi Frund	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Wm. R. Sweeney-7609 Exeter Rd. Beth. Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Second day anemia (Blood loss) DUE TO (c) Cervical carcinoma ^{CP LUNG} _{metastasis}		INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 weeks End of	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 21, 1959</u> , to <u>1/26/1959</u> , that I last saw the deceased alive on <u>1/26/1959</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D. ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>1/26/1959</u>			
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven	22d. LOCATION (City, town, or county) Silver Spring, Maryland (State)
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 28 '59	24b. REGISTRAR'S SIGNATURE <u>Naomi S. Frund</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
866 CERTIFICATE OF DEATH

00847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County, Maryland</i>				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>D. C.</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i> 47 X 1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Nursing Home</i>				d. STREET ADDRESS <i>3018 P St., N. W.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>CONSTANCE E. HOLDER</i>		First <i>E.</i>	Middle <i>HOLDE</i>	lost	4. DATE OF DEATH <i>December 23 1959</i>	Month <i>December</i>	Day <i>23</i>	Year <i>1959</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>1/20/1862</i>	9. AGE (In years lost/birthday) <i>79 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Wm. Thomas Payne</i>		14. MOTHER'S MAIDEN NAME <i>Pricilla Richards Entwistle</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Ers. Jos. Ives</i>	
								Address <i>N. Y. City (Daughter)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		DUE TO <i>450.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>General Arteritis</i>		DUE TO <i>(b) General Arteritis</i>		15 yrs.					
		DUE TO <i>(c) Senility</i>		5 yrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20. MEDICAL CERTIFICATION		21. I certify that I attended the deceased from <i>1957</i> , to <i>1959</i> , that I last saw the deceased alive on <i>1-20</i> , <i>1959</i> , and that death occurred at <i>10:15</i> p.m., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin P. Parker M.D.</i> ADDRESS <i>2015 R St., N. W. Wash., D.C.</i> DATE SIGNED <i>1/26/59</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/28/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemt.</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. F. Bickel & Sons</i>		ADDRESS <i>3034 M St. N. W., D.C.</i>		24a. REC'D BY REGISTRAR <i>JEN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Ward</i>			



FOR STATE
HEALTH DEPT.

1 DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00848

Reg. Dist. No.

867

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)					
Montgomery		a. STATE Maryland					
b. CITY OR TOWN (If out's de corporate limits, write RURAL and give nearest town)		b. COUNTY Md					
Silver Spring		c. CITY OR TOWN (If out's de corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Silver Spring					
8201 Cedar St.		8201 Cedar St.					
e. 13. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
Nelly Eastwood Holmead							
4. DATE OF DEATH		Month	Day				
Jan 18		1959					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 16 YEARS Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
Female		White		5-5-1885	73 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				N.J.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME					
Elsworth Eastwood		Seanne Hoffman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				John H. Holmead - Son 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) & (c)							
DUE TO Hypertension (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs -							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broachart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-18-59	
EXAMINER'S NAME (Type) Frank J. Broachart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		22b. DATE THEREOF 1/21/59		22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE G. J. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
868 CERTIFICATE OF DEATH

00849

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery County		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE MARYLAND Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 5½ days	b. COUNTY Montgomery				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Maryland	d. STREET ADDRESS 115 Chestnut Street				
3. NAME OF DECEASED (Type or print) Rose	First ALICE	Middle Hoopengardner	4. DATE OF DEATH Month 1 Day 1 Year 1959			
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/80	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME Nathan W. Mellott		14. MOTHER'S MAIDEN NAME Rebecca Garland				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 017 32 0659		17. INFORMANT Medical Records		Address Olney, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertension Cardiac (c) DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5 days Day 7 12.2.552				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 27, 1958 to Jan. 1, 1959 , that I last saw the deceased alive on Jan. 1, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jack Schumacher, M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) Jack Schumacher, M.D. Gaithersburg, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 5 1959	22c. NAME OF CEMETERY OR CREMATORIUM Whips Cove	22d. LOCATION (City, town, or county) Penn.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Barker, Taylorville, Md.</i>	ADDRESS <i>George Barker, Taylorville, Md.</i>	24a. REC'D BY REGISTRAR JAN 7 '59	24b. REGISTRAR'S SIGNATURE <i>C. J. L. Tamm</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG238 1-23-59 et

00850

869

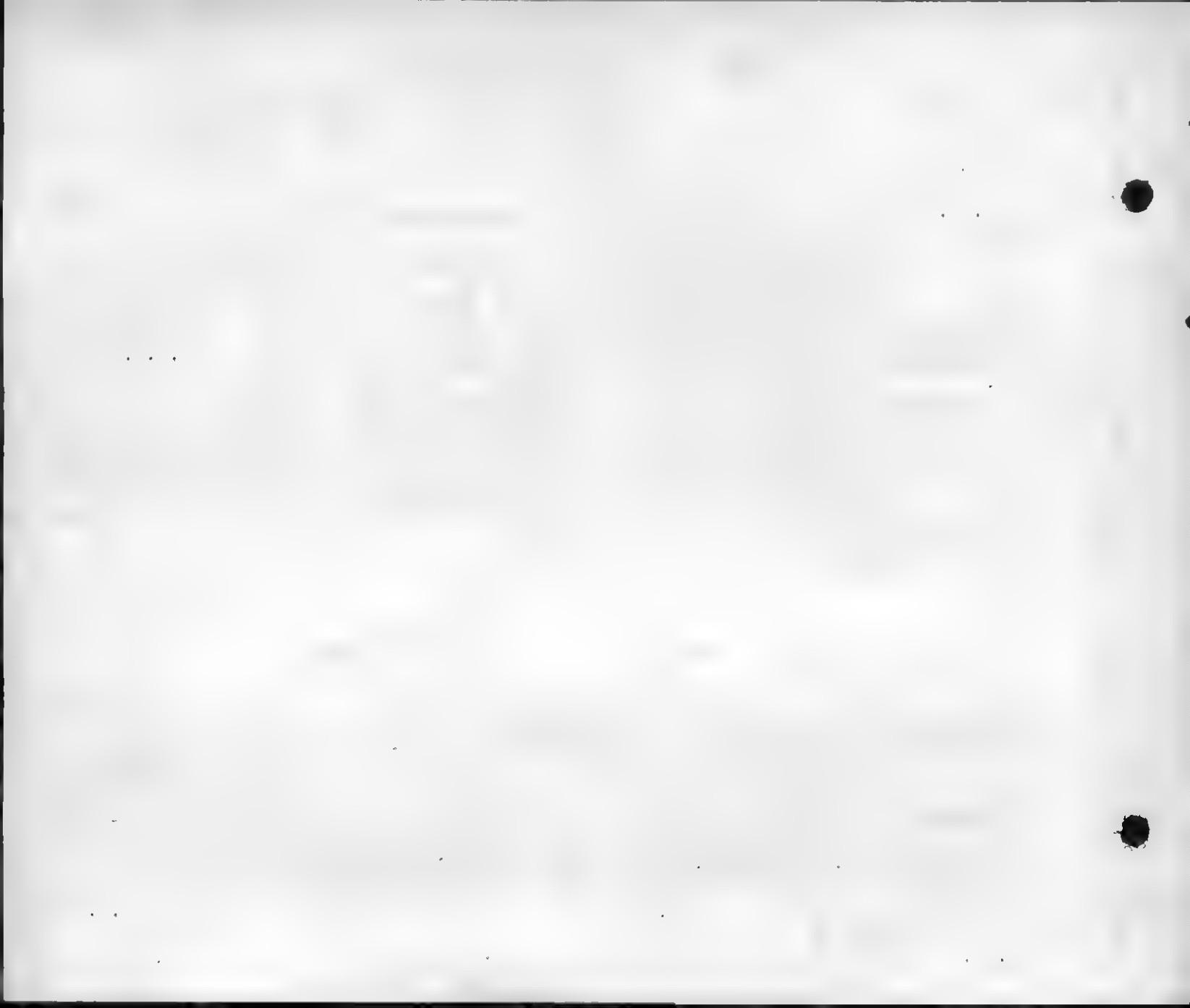
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 6024 Cheshire Drive		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Reuben HOOPER		First	Middle	Last	4. DATE OF DEATH January 22	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-1- 50 1879		9. AGE (In years last birthday) 70 79	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundryman		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME (Unknown) HOOPER		14. MOTHER'S MAIDEN NAME Frances HOOPER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-05-8309		17. INFORMANT (Sister) Arne Tervo, same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Pneumonia, Hypostasis				INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 2, 1959, to January 22, 1959, that I last saw the deceased alive on January 22, 1959, and that death occurred at 10:50 A.M. from the causes and on the date stated above ACTUAL SIGNATURE K. F. Spence Jr.						ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 1-22-59		
PHYSICIAN'S NAME (Type) K. F. SPENCE, JR.		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-59		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Washington (State) D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Funeral Home, 2901 14th St, NW, Wash. DC		ADDRESS S. H. Hines Funeral Home, 2901 14th St, NW, Wash. DC		24a. REC'D BY REGISTRAR DATE JAN 26 '59		24b. REGISTRAR'S SIGNATURE A. Hines & Son		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00851

769

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
75 Takoma Park		23 days		Silver Spring		120 Hamilton							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington Sanitorium & Hospital		d. STREET ADDRESS		120 Hamilton							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year					
Edna Louise		Howard			1	-	3	1959					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS			
Female White						4-27-08		50 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife		Own home		Maryland		America							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Eugene Brekke		Crissie Rickerd		No		none		Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		24 days			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Hypertensive heart disease							
		DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I attended the deceased from Feb. 1, 1959, to Feb. 3, 1959, that I last saw the deceased alive on Feb. 2, 1959, and that death occurred at 5:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED									
ACTUAL SIGNATURE		J. Marion Brinkhead M.D.		9241 301 BLD.		1-3-59							
PHYSICIAN'S NAME (Type)		J. Marion Brinkhead		SILVER SPRING MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county)		(State)					
1/6/59		CEDAR HILL CEMETERY		PRINCE GEO. COUNTY, MARYLAND									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
WALTER E. PUMPHREY, INC.		SILVER SPRING, MD.		JAN 7 '59		L. J. Lewis							
Raymond W. Gist Jr.													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

770

CERTIFICATE OF DEATH

00852

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on; Residence before admis on) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3208 Rolling Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carl		First	Middle G. Hultgren	Last	4. DATE OF DEATH Month Jan.	Day 31,	Year 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1884	9. AGE (In years last birthday) 69 74 yrs	10. IF UNDER 1 YEAR TT	11. IF UNDER 24 HRS 112 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Bureau of Standards		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.-Ret.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augusta Hultgren		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, rank or unknown) NO		16. SOCIAL SECURITY NO. 577-16-4859		INFORMANT Ida M. Hultgren - wife - as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) McGardens I. Braun DUE TO (c) Circumstances of Death DUE TO							
INTERVAL BETWEEN ONSET AND DEATH + days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-31-58 to 1-31-59 , 1959, that I last saw the deceased alive on 1-31-59 , 1959, and that death occurred at 8:30 AM , from the causes and on the date stated above							
ADDRESS (Street, city or town, state)							
DATE SIGNED 1-31-59							
ACTUAL SIGNATURE J. Raymond Ready M.D.							
PHYSICIAN'S NAME (Type) J. RAYMOND READY							
3701 Leland St., Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/59		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 4 '59	
						24b. REGISTRAR'S SIGNATURE Laura S. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page II may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

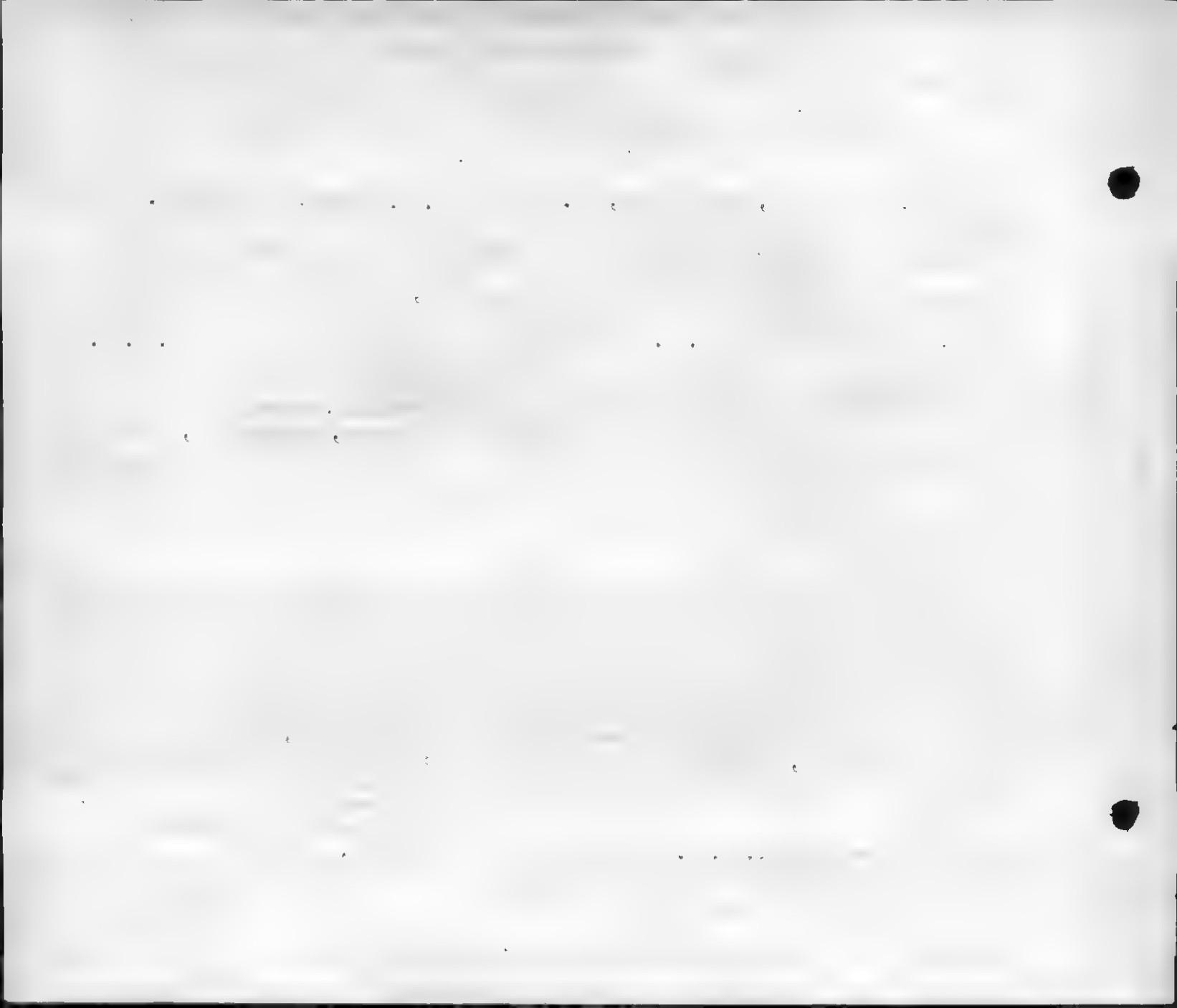
00853

870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE New York		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 46 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 9			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS c/o Mr. J. Jensen, 619 80th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellen	Middle (None)	Last Ingwersen	4. DATE OF DEATH January	Month Day	Day 16	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 28, 1914	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Ingwersen		14. MOTHER'S MAIDEN NAME Olga Danielsen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X		<i>Carcinoma breast with bony metastases</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) <i>central nervous system depression</i>					
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Queens, New York		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 1958 , to January 16, 1959 , that I last saw the deceased alive on January 16, 1959 , and that death occurred at 7:15a M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1-16-59	
ACTUAL SIGNATURE <i>Rufus Schwab</i>		M.D.					
PHYSICIAN'S NAME (Type) Paul Schwab, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORIUM CYPRESS HILLS		22d. LOCATION (City, town, or county) QUEENS, NEW YORK (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gavleis Jr.</i>		ADDRESS 1756 Pa. Ave., N.W.D.C.		24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00854

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)		Reg. Dist. No.									
				a. STATE Maryland	b. COUNTY Montg.										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cabin John		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
				X Cabin John											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Fire House, Cabin John		d. STREET ADDRESS		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
				6914 Seven Locks Rd.											
3. NAME OF DECEASED (Type or print)		First	Middle	lost	4. DATE OF DEATH	Month	Day	Year							
John Raymond Iverson					JAN 6, 1959			19							
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS								
male		col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/11/1903	55 yrs	Months	Days	Hours	Min						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
LABORER				Maryland		USA									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address											
John R. Iverson		Daisy Jones													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <small>If yes, give war or dates of service)</small>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH sudden			
						Coronary Occlusion									
420.1		DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)													
		DUE TO													
		(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
19															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Frank J. Broschart MD						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED					
EXAMINER'S NAME (Type)		Frank J. Broschart						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)							
Burial		1-10-1959		Moses Cemetery Cabin John MD											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
W. ERNEST JARVIS Jr.		1432 YOUNG ST. N.W. WASHINGTON, D.C.		DATE JAN 12 '59		Ernest S. Jarvis									
VS AT5ME		SM 2 57													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00855

876 Items 1, 3, 8, 9, 13 Filing 10 2-2-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CABIN JOHN</i> Brookmont			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARMY MAP SERVICE, 6500 BROOKS LANE			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. STREET ADDRESS 11,719 COLLEGE VIEW DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)		First Satoru Middle	Lost	4. DATE OF DEATH JAN. 19	Month Day Year
HARVEY / SATORU		IWATA		JAN.	19 1959

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years <small>or fraction</small>)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
MALE	Mongolian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/16/93	4-16-03 /56 53 yrs.	Months Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ass't. Branch Chief of Geographic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOV'T.</i>	11. BIRTHPLACE (State or foreign country) <i>FRESNO, CALIFORNIA</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>PASOJI IWATA</i> , Tasoji	14. MOTHER'S MAIDEN NAME <i>SUYE SAKUMA</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT	Address
NO	564-20-5316	Mr. Harvey M. Iwata, 11,719 College View Drive	Silver Spring, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INITIAL INTERVAL ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion -</i>		
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Rheumatic Heart Disease -</i>		
DUE TO		
(c) <i>10 yr.</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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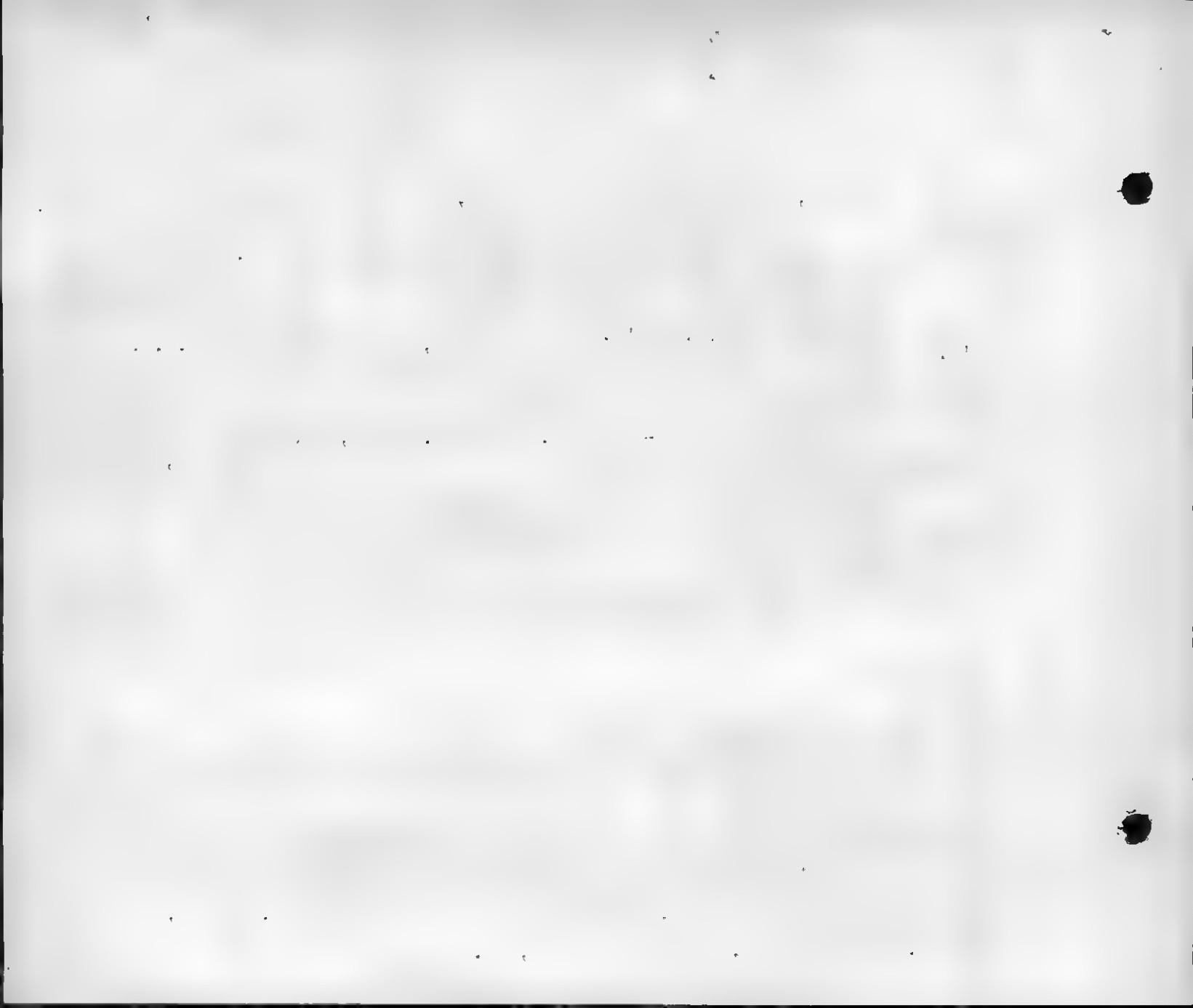
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>John G. Ball</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 1/19/59
EXAMINER'S NAME (Type) JOHN G. BALL		

22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 1/24/59	22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL	22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND
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23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond C. Ball</i>	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE JAN 22 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. King</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

873 CERTIFICATE OF DEATH

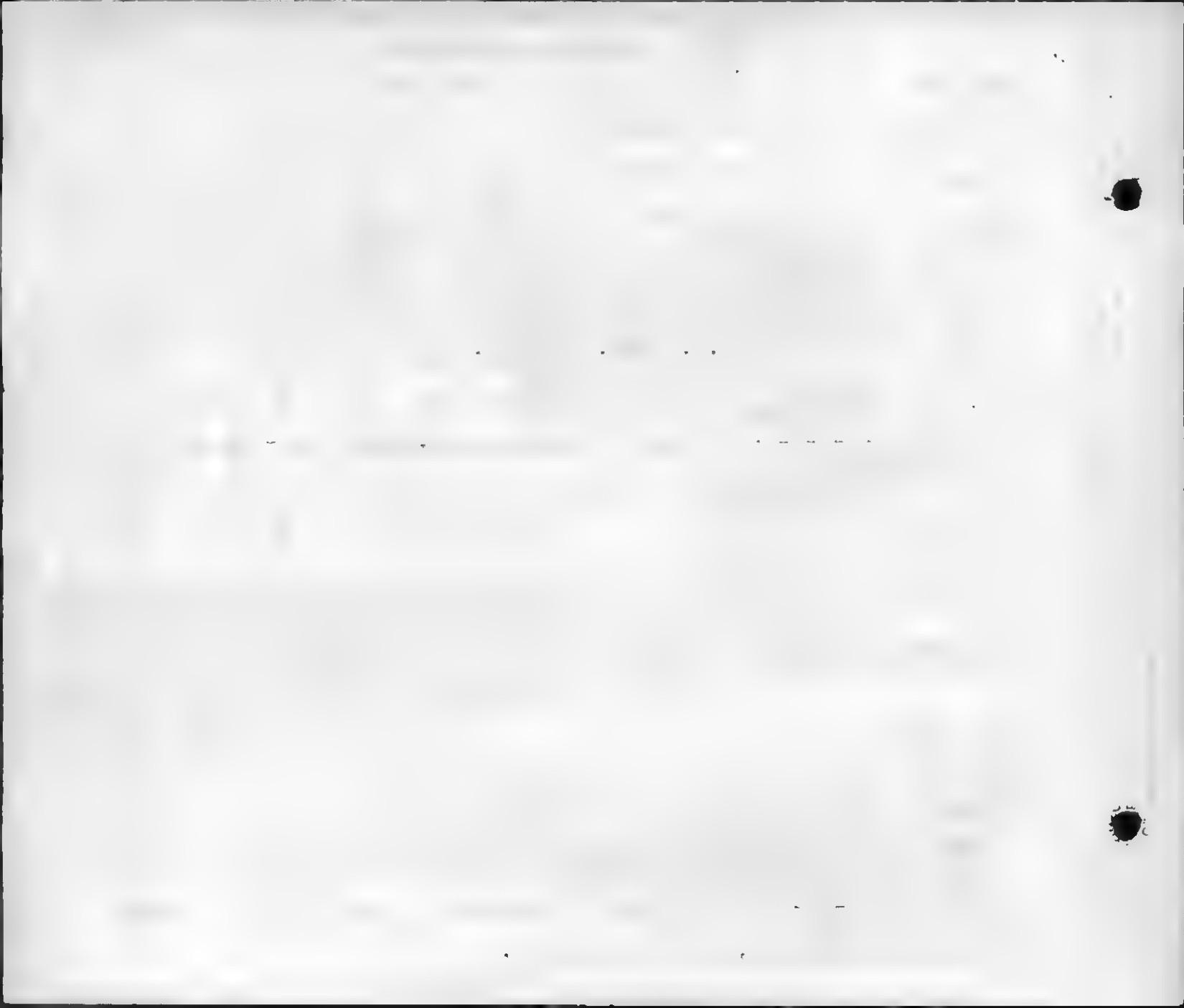
00856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
<i>Montgomery</i> Maryland		D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i>	<i>14 days</i>	<i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Saburbian</i>		<i>3914 McKinley St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>George</i>		<i>Jamieson</i>	
4. DATE OF DEATH	Month	Day	Year
<i>Jan 26</i>	<i>Jan</i>	<i>26</i>	<i>1959</i>
5. SEX	6. COLOR OR RACE	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH
<i>m</i>	<i>white</i>	<i>June 7 1880</i>	8. AGE (In years from birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? Address
<i>Chemist</i>	<i>U.S. Dept. of Agri. Conn.</i>	<i>Conn.</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>George A Jamieson</i>	<i>Edith Burns</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
			<i>Right hemiplegia, severe</i>
			DUE TO <i>334X</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	<i>Arteriosclerosis, general</i>	
	(c)	5 yrst	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Uremia, terminal due to nephrosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>1956</i> , to <i>Jan 26</i> , 1959, that I last saw the deceased alive on <i>Jan 26</i> , 1959, and that death occurred at <i>9:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stewart Clapp</i>	M.D. <i>3921 Ingleside St. N.W.</i>	ADDRESS (Street, city or town, state) <i>Wash 15 DC.</i>	DATE SIGNED <i>1-27-59</i>
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-29-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda 14, Md.</i>		24a. REG'D BY REGISTRAR <i>MR. R. A. PUMPHREY</i>	24b. REGISTRAR'S SIGNATURE <i>R. A. PUMPHREY</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



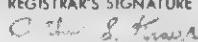
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

874

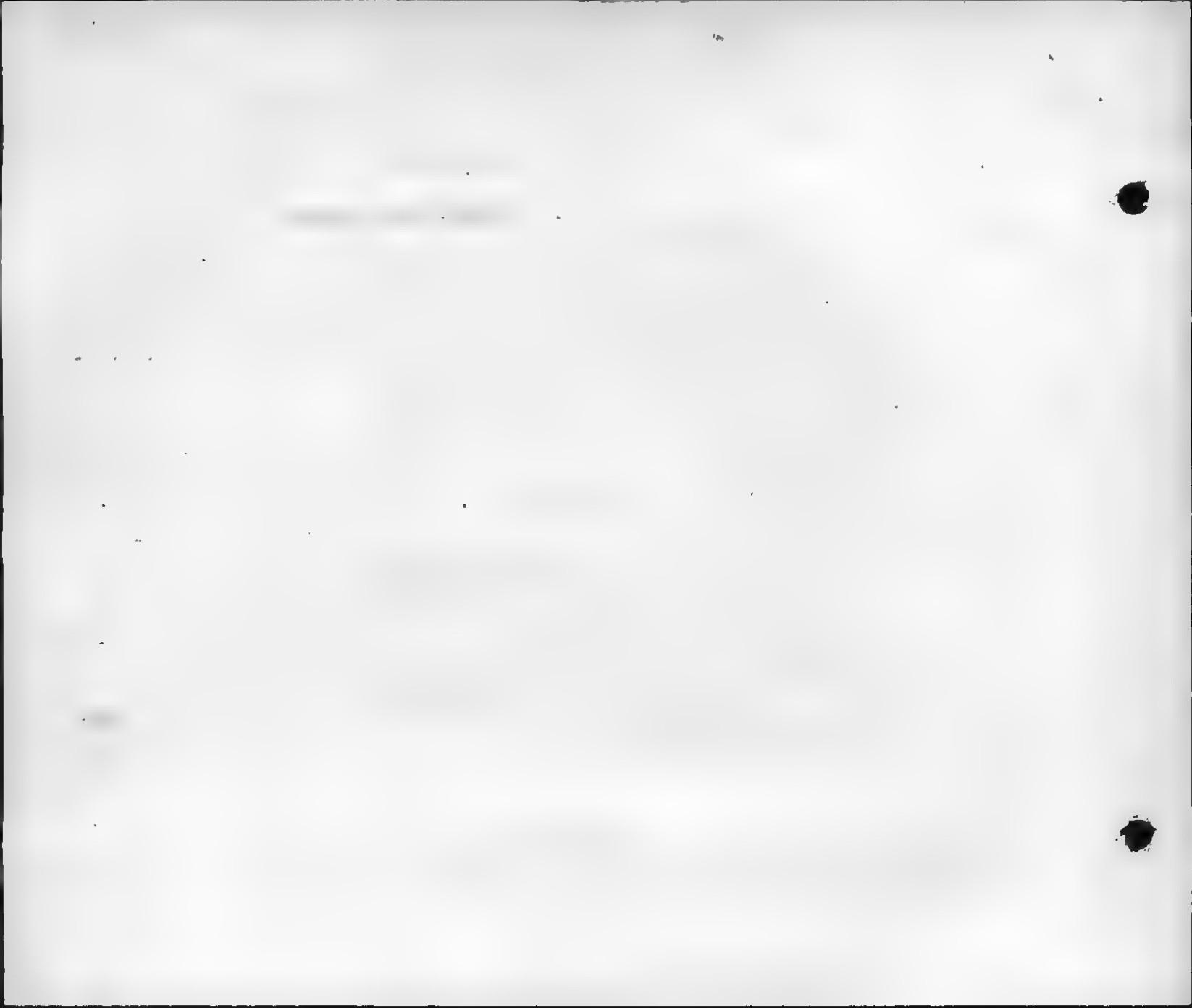
CERTIFICATE OF DEATH

00857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS - 4315-30th Street	
3. NAME OF DECEASED (Type or print) Donald		First Middle John	4. DATE OF DEATH Month January Day 8 Year 1959
5. SEX Male		6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH December 25, 1937		9. AGE (In years lost b/rthday) 21 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster & Engraver		10b. KIND OF BUSINESS OR INDUSTRY Engraving	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Donald L. John		14. MOTHER'S MAIDEN NAME Mildred Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO Unascertainable	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>free cusp of aortic valve.</u> Rupture of the right coronary and DUE TO <u>Fibrinous pericarditis with massive effusion</u> 1-2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bacterial endocarditis, aortic & tricuspid valve</u> 3 wks (c) <u>source of infection, purulent left suprapatellar bursitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 29, 1958, to January 8, 1959, that I last saw the deceased alive on January 8, 1959, and that death occurred at 5:40 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 1-9-59			
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) John P. Nasou, M. D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-59	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln
22d. LOCATION (City, town, or county) (State) Prince George Co., Md.		24a. REC'D BY REGISTRAR DATE JAN 12 1959	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trans. permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File # 771-20-53 et

00858

771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE D. C. Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		Washington 47X		
d. NAME OF HOSPITAL OR INSTITUTION 517 Albany Avenue Oak Haven Rest Home				d. STREET ADDRESS 424 Oneida Pl., N.W. 517 Albany Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First E/M: A B	Middle Johnson	Lost	4. DATE OF DEATH Jan. 7, 1959	Month	Day	Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/8/1868	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Hellows		14. MOTHER'S MAIDEN NAME Emma Evans						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Elizabeth M. Johnson		Address Wash. DC 424 Oneida Pl. N.W.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO Influenza) Syndrome,						INTERVAL BETWEEN ONSET AND DEATH 10 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO non Specific Paroxysm		(c) Weakness and inanition				20 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old age 91						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) M.D.		(County)		(State)
21. I certify that I attended the deceased from 1/2/57, 1957 to 1/7/59, 1959, that I last saw the deceased alive on 1/6/59, 1959, and that death occurred at 7:35 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 500 Underwood St. N.E.		
ACTUAL SIGNATURE Charles H. Wolchon						DATE SIGNED 1/7/59		
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hed. J. News Co., 2901 N. Glebe Rd. N.W.		ADDRESS 2901 N. Glebe Rd. N.W.		24a. REC'D BY REGISTRAR Date Jan 10 1959		24b. REGISTRAR'S SIGNATURE L. M. S. Trans		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

875

CERTIFICATE OF DEATH

00853

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 5 mo.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 916 - Hollywood Ave.				d. STREET ADDRESS 916 - Hollywood Ave.			
3. NAME OF DECEASED (Type or print) Clarence		First Ellsworth	Middle Kane	Last	4. DATE OF DEATH Month Jan.	Day 28	Year 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1898	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper Retired				10b. KIND OF BUSINESS OR INDUSTRY Altimore, Md.		11. BIRTHPLACE (State or foreign country) Altimore, Md.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-5253		17. INFORMANT Rosalie Hansford		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Esophageal Varices INTERVAL BETWEEN ONSET AND DEATH 1 yr. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) metastatic Carcinoma of Liver DUE TO (c) Carcinoma, Gastric							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor	(County) Md.
21. I certify that I attended the deceased from October 18, 1958 to January 29, 1959 , that I last saw the deceased alive on Jan. 29, 1959 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1222 Monroe St. N.E.							
DATE SIGNED 12/22/58							
ACTUAL SIGNATURE Bald J. Vosger							
PHYSICIAN'S NAME (Type) A. Bald J. Vosger							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-31-59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor	
(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Nallev's Funeral Home Inc.		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE Feb 3 '59		24b. REGISTRAR'S SIGNATURE John J. Vosger	

United neglect train brook

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			b. COUNTY <i>Montgomery</i>		
c. LENGTH OF STAY IN 1B <i>14 days</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery General Hospital</i>			d. STREET ADDRESS <i>Montgomery 1000 E. 37th St.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Joseph (J. M.) Kaplan</i>			First	Middle	Last
4. DATE OF DEATH Month Day Year <i>Dec. 10 1959</i>			Month	Day	Year
5. SEX <i>Male</i>			6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/12/1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business executive</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>		
10c. BIRTHPLACE (State or foreign country) <i>Russia</i>			11. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>Hershey Kaplan</i>			14. MOTHER'S MAIDEN NAME <i>Katzman Ethel</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>123-45-6789</i>		
17. INFORMANT <i>John Kaplan</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>47</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>in 2 weeks</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Stomach tend failure</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) <i>None</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rosedale</i>			20f. (City or town) (County) (State) <i>Baltimore</i>		
21. I certify that I attended the deceased from <i>12-27-1959</i> to <i>1-10-1959</i> , that I last saw the deceased alive on <i>1-6-1959</i> , and that death occurred at <i>2:05 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. Kaplan</i> M.D. ADDRESS <i>7601 Carroll Ave</i> DATE SIGNED <i>1/10/59</i>					
PHYSICIAN'S NAME (Type) <i>Charles H. Kaplan</i>					
22a. BURIAL, CREMATION, REMOVAL (Spec.) <i>Burial</i>			22b. DATE THEREOF <i>1-11-58</i>		
22c. NAME OF CEMETERY OR CREMATORIAL <i>Rosedale</i>			22d. LOCATION (City, town, or county) <i>Baltimore</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Levesque</i>			ADDRESS <i>2100 Eastern Place</i>		
24a. REC'D BY REGISTRAR DATE <i>JAN 13 '59</i>			24b. REGISTRAR'S SIGNATURE <i>Walter J. Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4,17, 9 & 11 G237

876

875

CERTIFICATE OF DEATH

00863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.			b. COUNTY Montgomery								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 8 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington			d. STREET ADDRESS 4101 Knowles Avenue								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Mrs. Mary E. Keene			First	Middle	Last	4. DATE OF DEATH February 26, 1884	Month 1	Day 1	Year 59	5. SEX F	6. COLOR OR RACE 1. P	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 10	Days 8	Hours 1	Min 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U. S. .								
13. FATHER'S NAME Mr. Harry Carter			14. MOTHER'S MAIDEN NAME Mary Emily														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Herbert N. Keene Address 10414 Parkwood Dr Kensington, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Anteriosclerotic Heart disease Unknown									INTERVAL BETWEEN ONSET AND DEATH 1 year								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1) Myxedema 2) Vitamin deficiency - multiple									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1160 2 Georgia Ave			(City or town) Washington, D. C.		(County) District of Columbia	(State) D.C.					
21. I certify that I attended the deceased from Dec 27, 1958 , to 1-4-59 , 19 59 , that I last saw the deceased alive on 1-1-59 , 19 59 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D.									DATE SIGNED 1-4-59.								
ACTUAL SIGNATURE Morris Perry																	
PHYSICIAN'S NAME (Type) Morris Perry																	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/7/58			22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery			22d. LOCATION (City, town, or county) Washington, D. C.			(State) D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland			ADDRESS 1160 2 Georgia Ave			24a. REC'D BY REGISTRAR Open 7 50			24b. REGISTRAR'S SIGNATURE Carter & Co.								

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

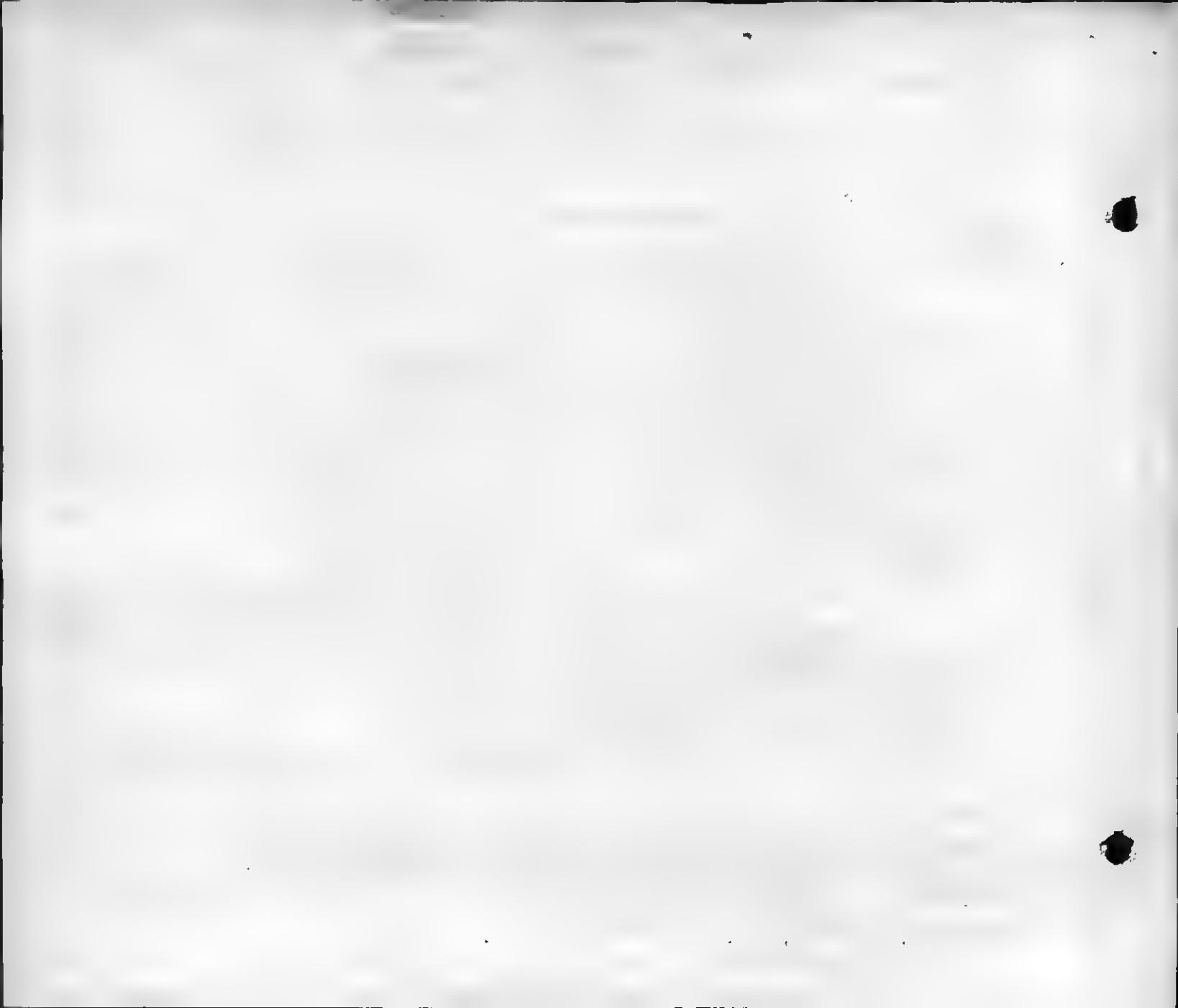
773

CERTIFICATE OF DEATH

00862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park Md</i>		c. LENGTH OF STAY IN lb <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>307 Warrenton Drive</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>John Leedy Kessinger</i>		First	Middle	Lost	4. DATE OF DEATH <i>Jan. 27 1959</i>	Month	Day	Year
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>6-16-10</i>		9. AGE (In years last birthday) <i>48</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Broker SELF EMPLOYED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Missouri</i>		11. BIRTHPLACE (State, or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Andrew J. Kessinger</i>		14. MOTHER'S MAIDEN NAME <i>Leedy Ella MackKessinger</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>Yes I was II</i>		16. SOCIAL SECURITY NO. <i>263-07-0004</i>		17. INFORMANT <i>Andrew J. Kessinger, SILVER SPRING, MD.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<i>Hypocardial Infarction</i>						
DUE TO		<i>Coronary Occlusion</i>				<i>2 months</i>		
(b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) (State)
21. I certify that I attended the deceased from <i>Jan 16 1959</i> , to <i>Jan 27 1959</i> , that I last saw the deceased alive on <i>Jan 20 1959</i> , and that death occurred at <i>12:45 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>8248 George Ave - 112859</i>		DATE SIGNED
ACTUAL <i>Merrill M. Cross</i>								
PHYSICIAN'S NAME (Type) <i>MERRILL M. CROSS</i>						<i>Silver Spring Maryland</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/30/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MARYLAND</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>W. S. Thorne</i>		



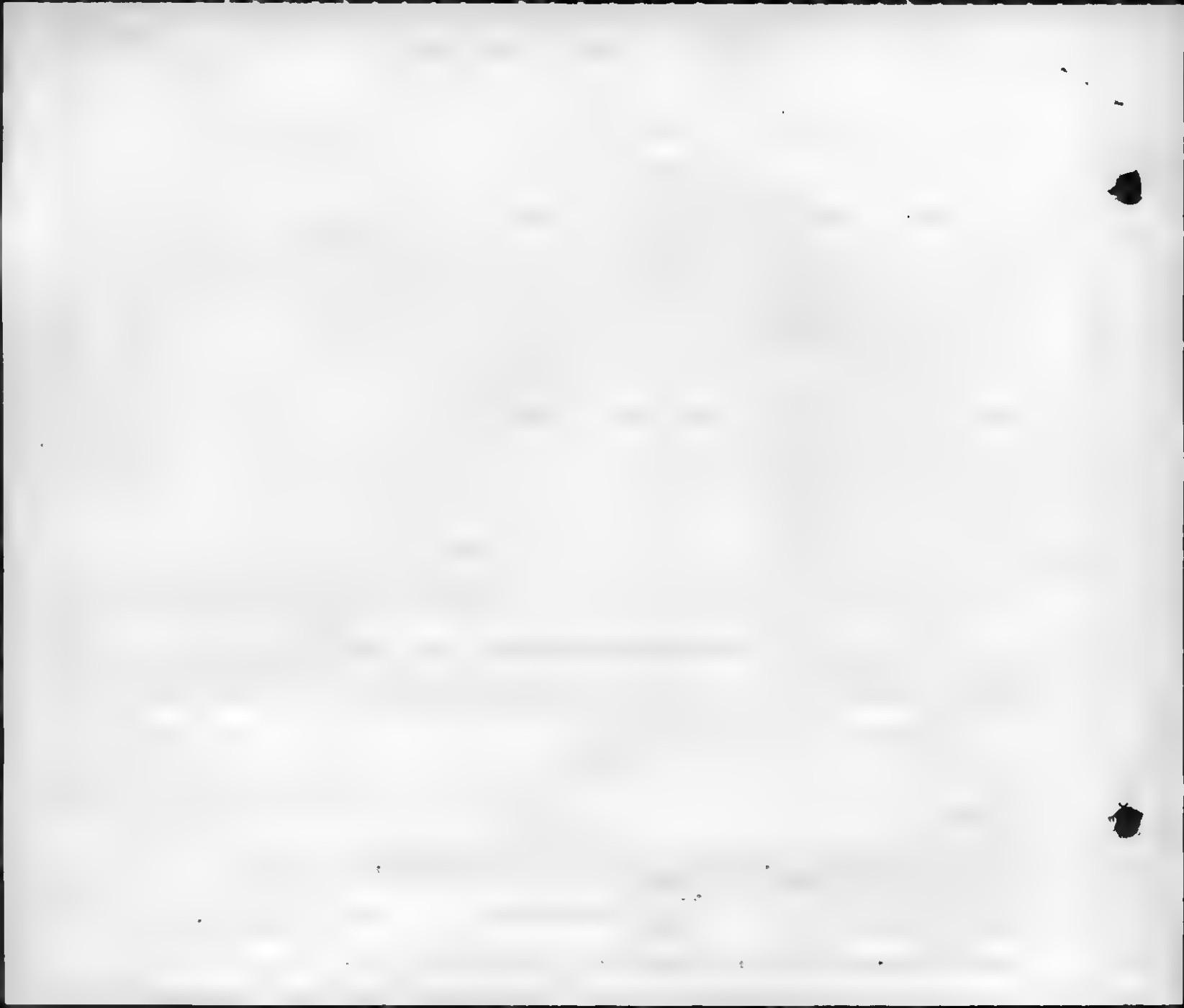
MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
793 CERTIFICATE OF DEATH

00863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>10 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12201 Rockville Pike</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
3. NAME OF DECEASED (Type or print) <i>Alverda C. Kingdon</i>		First	Middle
4. DATE OF DEATH <i>JAN. 3rd</i>		Last	Month Day Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/14/1881</i>
9. AGE (In years lost birthday) <i>74 yr</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <i>11 37</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
10c. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>		11. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>John Kingdon</i>		14. MOTHER'S MAIDEN NAME <i>Alverda</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. & Mrs. P. W. Jones</i>		Address <i>7201 Rockville Pike, Rockville, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral anoxia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>cerebral thrombosis</i>		10 days	
DUE TO <i>cerebral arteriosclerosis</i>		Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1, 1959</i> to <i>1/3/59</i> , that I last saw the deceased alive on <i>1/3/59</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Stephen N. Jones</i>		ADDRESS (Street, city or town, state) <i>Rockville, Md.</i> DATE SIGNED <i>1/3/59</i>	
PHYSICIAN'S NAME (Type) <i>Stephen N. JONES</i>		M.O.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF	
		22c. NAME OF CEMETERY OR CREMATORIAL <i>Rockville Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Rockville, Maryland</i>		22d. LOCATION (City, town, or county) <i>Rockville, Md.</i>	
		24a. REC'D BY REGISTRAR DATE <i>JAN 7 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>1/14/59</i>	

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

877

CERTIFICATE OF DEATH

Reg. Dist. No.

90864

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE			
Montgomery Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda	8 hours	Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Suburban Hospital	524 Calvin lane				
3. NAME OF DECEASED (Type or print)	First Marie	Middle Agnes	Last Kirby		
4. DATE OF DEATH	Month January	Day 28	Year 1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 24, 1890		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Homemaker		Brooklyn, New York	U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
William Timmins	LXXX Margaret Norman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
		Son Mr. Jerome F. Kirby	As above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Acute Peritonitis</u> INTERVAL BETWEEN ONSET AND DEATH					
550.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Suggestive Appendicitis & Perforation</u>					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that I attended the deceased from <u>1-27</u> , 1959, to <u>1-28</u> , 1959, that I last saw the deceased alive on <u>1-27</u> , 1959, and that death occurred at <u>M.</u> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE	<u>W.G. Hall</u> M.D. <u>615 W Montgomery Ave Rockville Md 1-2859</u>				
PHYSICIAN'S NAME (Type)	W. G. Hall 615 Montg. Ave., Rockville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)	
Burial	1/31/59	Mt. Olivet Cemetery	Washington, D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md			24a. REC'D BY REGISTRAR JAN 30 '59	24b. REGISTRAR'S SIGNATURE <u>John S. Trauma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



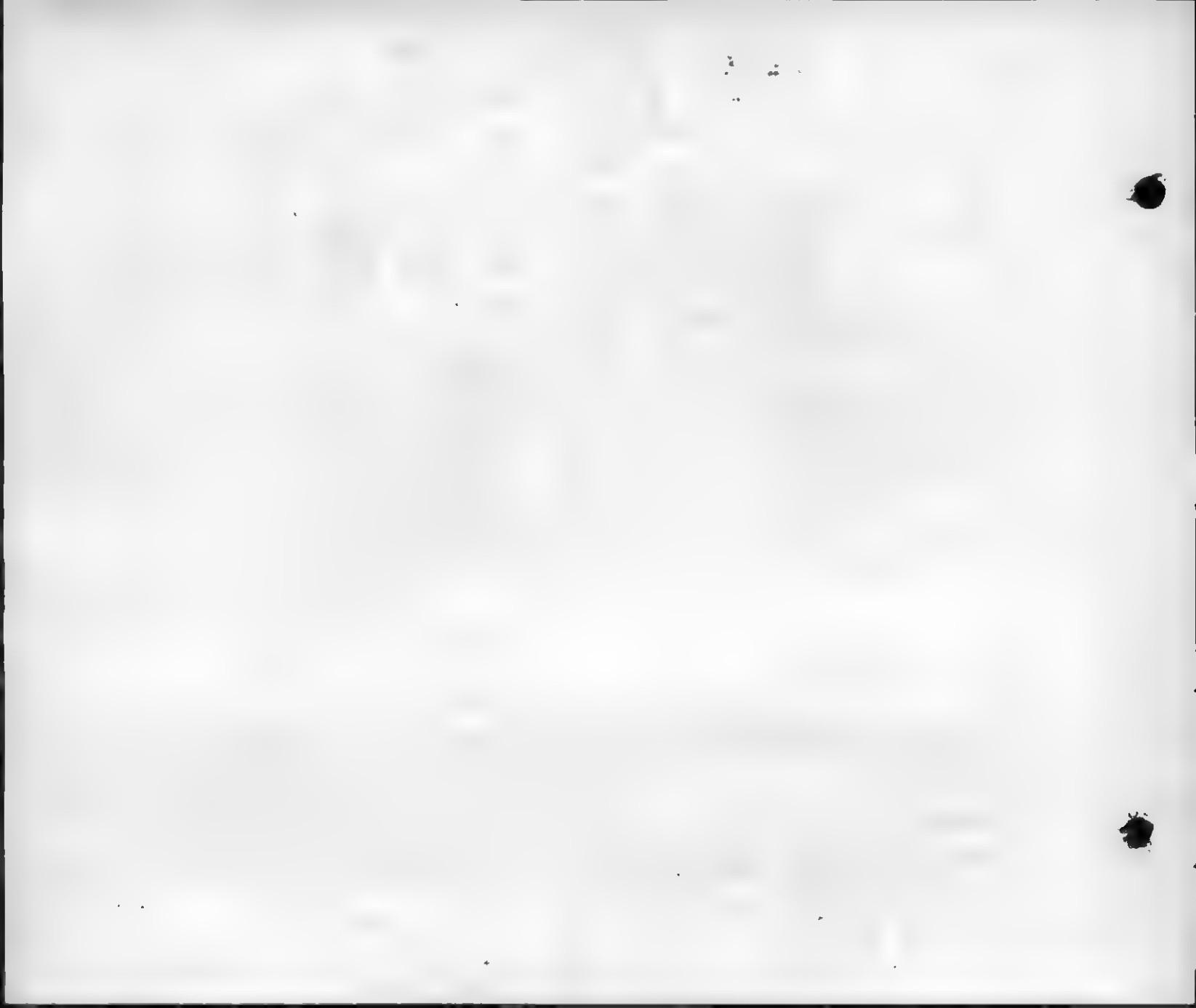
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 File No. 1-19-59 set
CERTIFICATE OF DEATH

Reg. Dist. No. **00865**

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lennie	Middle Mae	Last Kirk
4. DATE OF DEATH	Month January	Day 8	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.12.94
9. AGE (In years (last birthday)) 64 62 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Virginia	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Henry C. Flanary	14. MOTHER'S MAIDEN NAME Gladys Ann Willis	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) (If yes, give war or date of service) NONE	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Hospital Records	
IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes (coma)			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Hemiplegia right			
DUE TO			
(c) Hypothyroidism			
INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from January 1, 1959 , to January 8, 1959 , that I last saw the deceased alive on January 8, 1959 , and that death occurred at 11:17 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>J. W. Bird</i>	M.D.		ADDRESS (Street, city or town, state) Sandy Spring, Maryland
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.	DATE SIGNED 1/8/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 10 59	22c. NAME OF CEMETERY OR CREMATORIUM Jonesville	22d. LOCATION (City, town, or county) (State) Jonesville Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W. Barber</i>	ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE JAN 12 '59	24b. REGISTRAR'S SIGNATURE <i>W. J. Lucas</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00865

879

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Ann Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>75 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		e. STREET ADDRESS <u>15 Monroe Court</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Joseph Arthur KLEIS</u>		First <u>Joseph</u>	Middle <u>Arthur</u>	Last <u>KLEIS</u>	4. DATE OF DEATH <u>January 14 1959</u>	Month <u>January</u>	Day <u>14</u>	Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-04</u>	9. AGE (In years, months, days) <u>54 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 14 HRS Days <u>0</u>	12. Hours <u>0</u>	13. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank M. KLEIS</u>				14. MOTHER'S MAIDEN NAME <u>Anne Lillian Boniarski</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>WWII</u>		17. INFORMANT <u>(W) Mrs. Audrey M. Kleis, same as #2 above</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced inactivity</u> DUE TO (c) <u>Multiple internal (heart) and external</u> DUE TO								
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>October 31, 1958</u> , to <u>January 14, 1959</u> , that I last saw the deceased alive on <u>January 13, 1959</u> , and that death occurred at <u>4:40A.M.</u> from the causes and on the date stated above								
ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE <u>J. M. Young</u>		M.D. <u>U. S. Naval Hospital, NNMC</u> <u>1-14-59</u>						
PHYSICIAN'S NAME (Type) <u>J. M. YOUNG, LT, MC, USN</u>		Bethesda, 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Mount Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.L. Hopping Funeral Home, Annapolis, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		
VS A15 (4) 1SM 10/57		DATE JAN 16 '59						



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME BM 2/57

FOR STATE
HEALTH DEPT.

Items 18&21 Film

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CC867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3518 Bradley Lane				/ STREET ADDRESS 3518 Bradley Lane		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) CHRISTOPHER H.		First	Middle	Lost	4. DATE OF DEATH January 24,	Month	Doy	Year 19 59							
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 30, 1928	9. AGE (in years incl. birthday) 30	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS Days 14	12. IF UNDER 24 MIN Hours Min							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Actor		10b. KIND OF BUSINESS OR INDUSTRY Theater		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? US									
13. FATHER'S NAME Walter Kotschnig		14. MOTHER'S MAIDEN NAME Elined Prys		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown									
17. INFORMANT Walter Kotschnig-Item# 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carbon monoxide poisoning													
973.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found dead in closed car in closed garage at home				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Frank J. Broschart		23. EXAMINER'S NAME (Type) Frank J. Broschart		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/24/59							
22a. BURIAL OR CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DAWN 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00868

881

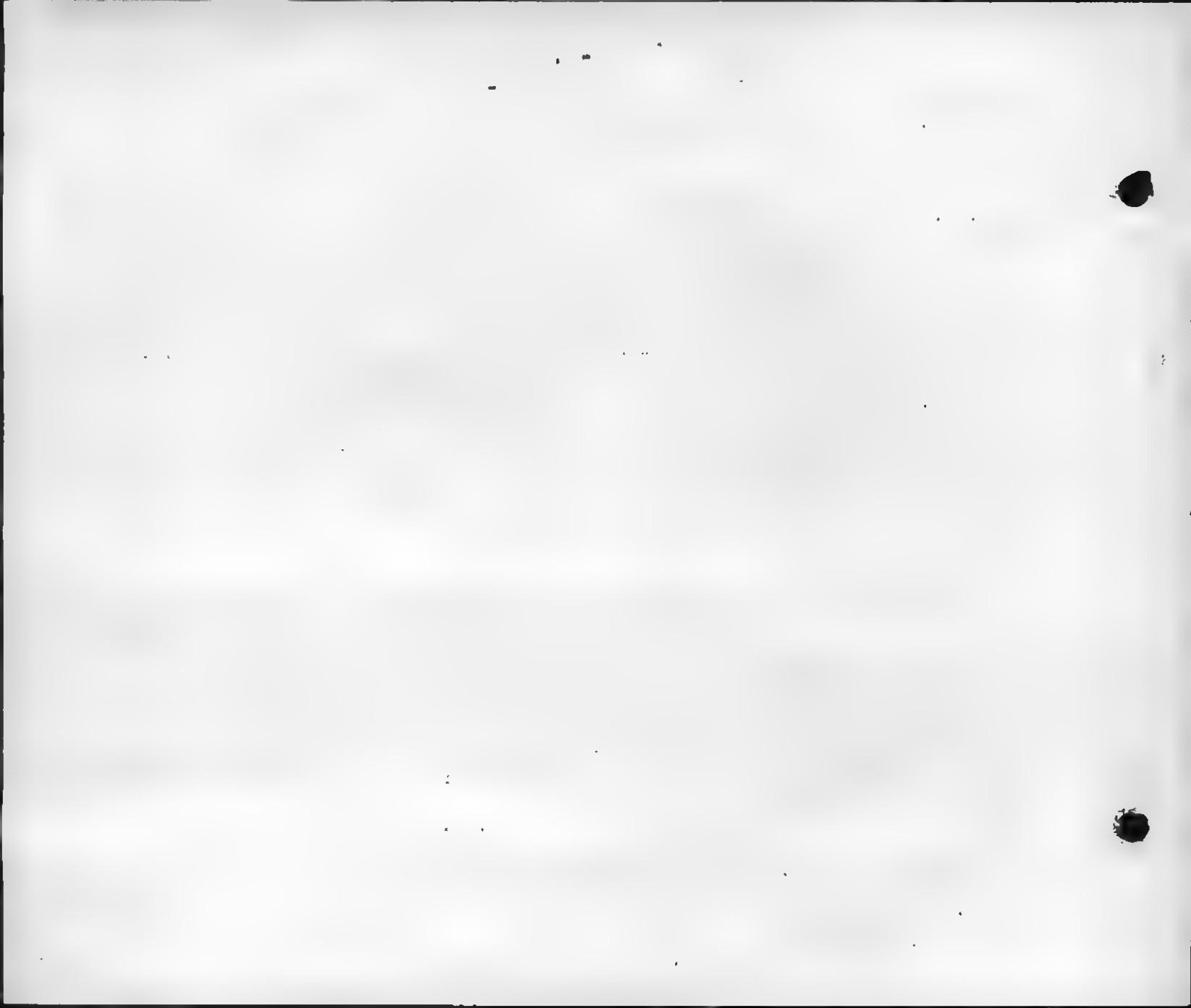
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. STREET ADDRESS 44 Forrester Street, S. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Frederick	Middle Joseph	Last KRUEGER	4. DATE OF DEATH Month January	Day 27	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-27-59	9. AGE (in years last birthday) yrs. 5	IF UNDER 1 YEAR IF UNDER 24 HRS Months 5 Days 4 Hours 5 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME John W. KRUEGER			14. MOTHER'S MAIDEN NAME Shirley Jo FREEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) John W. Krueger, same as #2 above		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c) <i>Congenital Alectasia</i>						
INTERVAL BETWEEN ONSET AND DEATH 8 hr						
Choroidal Atresia						
5 hr						
Multiple Congenital Anomalies						
5 hr.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 27, 1959 , to January 27, 1959 , that I last saw the deceased alive on January 27, 1959 , and that death occurred at 8:42 P.M. from the causes and on the date stated above						
ADDRESS (Street, city or town, state)						
DATE SIGNED 1-27-59						
ACTUAL SIGNATURE <i>Kenneth W. Sell</i>						
PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN						
Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 1-29-59		22c. NAME OF CEMETERY OR CREMATORIUM Catholic Cemetery		22d. LOCATION (City, town, or county) Emporia
(State) Kansas						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>		ADDRESS 4748 Wisc. Ave. NW, Washington D.C.		24a. REC'D BY REGISTRAR DATE JAN 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00863

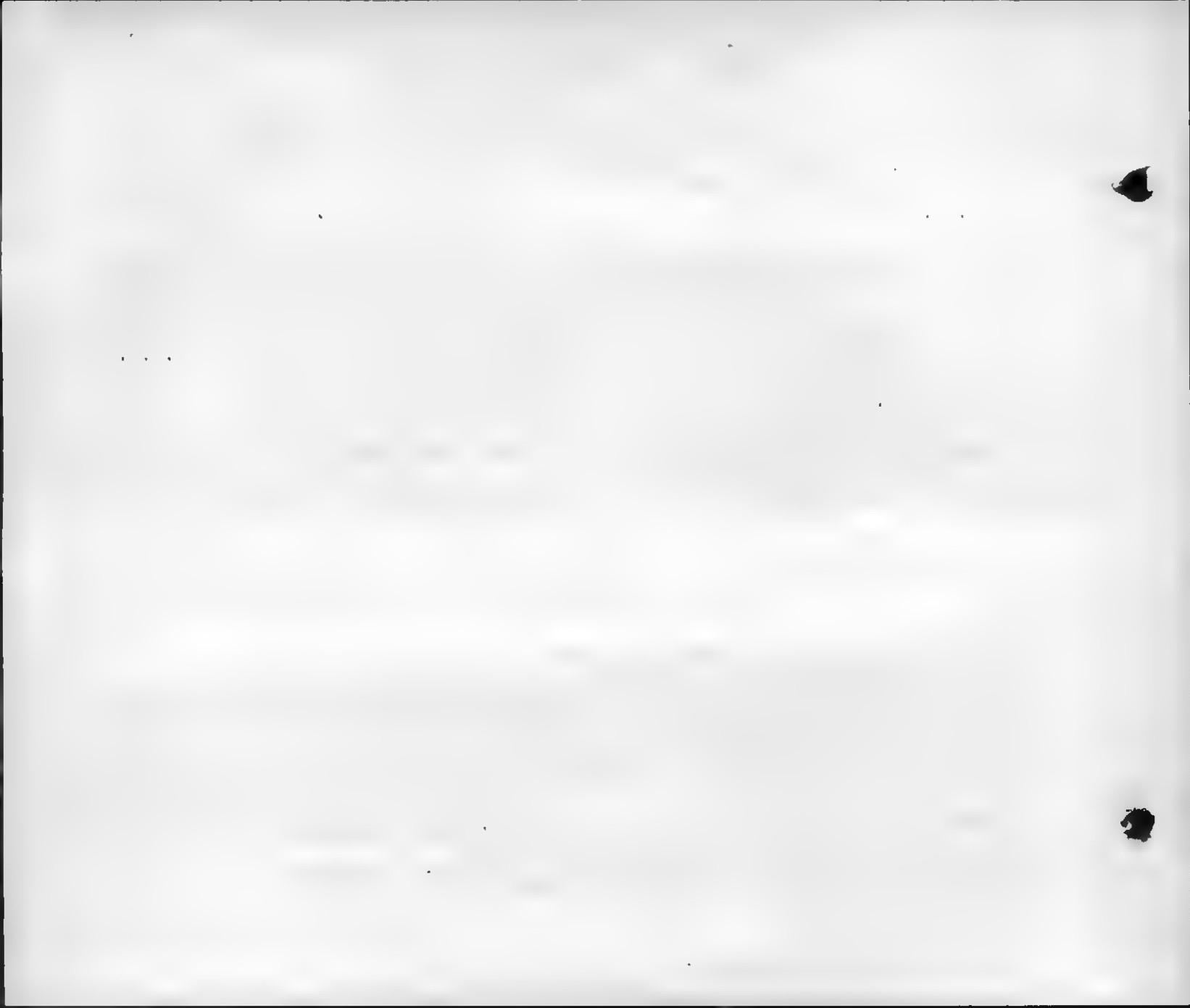
882

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York		b. COUNTY New York		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 685 West End Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Howard	Middle Bennett	Last LEONARD	4. DATE OF DEATH January 15 1959	Month Day Year			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 12-6-09	9. AGE (In years (last birthday) 49 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Oliver H. LEONARD				14. MOTHER'S MAIDEN NAME Nellie BENNETT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 16/42 to 6/45		17. INFORMANT Official Navy Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Severe general Inflammation</i> DUE TO (c) <i>Lymphosarcoma & wide system involvement</i> 3 years								
INTERVAL BETWEEN ONSET AND DEATH 1 mo								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 24, 1958 , to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 10:23A M , from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. H. O'Connell</i> PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN ADDRESS Bethesda 14, Maryland DATE SIGNED 1-15-59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-16-59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hills		22d. LOCATION (City, town, or county) Suitland (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. J. Humphrey Funeral Home, Bethesda, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE <i>Ernest S. Mann</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 3 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 774-en 22 Feb 1959 1-30-59 et
CERTIFICATE OF DEATH

00870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Maryland				c. LENGTH OF STAY IN lb 2hrs.-26min d. STREET ADDRESS Hyattsville,					
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitorium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Female		White		Lewis	1	-20		1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-59	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		Months	Days	Hours	Min
						2	26		
13. FATHER'S NAME Frank Hugo Lewis				14. MOTHER'S MAIDEN NAME Rebecca Mae Flowers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No				16. SOCIAL SECURITY NO		17. INFORMANT Mother's record			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				I immaturity					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6480 New Hampshire Ave., Takoma Park, Md.		(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL Julius S. River M.D. PHYSICIAN'S NAME (Type) Julius S. River M.D. 6480 New Hampshire Ave., Takoma Park, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) -		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORIAL Hospital disposal		22d. LOCATION (City, town, or county) 6480 New Hampshire Ave., Takoma Park, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR OPEN 28 '59		24b. REGISTRAR'S SIGNATURE Julius S. River	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

883

CERTIFICATE OF DEATH

00871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	c. LENGTH OF STAY IN 1b Since 1/1/59	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHEVY CHASE						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Avenue	d. STREET ADDRESS 6915 Ridgewood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JULIUS	Middle CHRISTIAN	Last LINK	4. DATE OF DEATH JAN. 8 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/79	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diamond setter (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHAN CHRISTIAN LINK			14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 135-09-7528		17. INFORMANT Mr. William J. Link, 6915 Ridgewood Ave.	Address Chevy Chase, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Carcinoma, urinary bladder 20 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) & metastasis to rectum + other 34 yrs. (c) adjacent structures, & to skull (?)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 1948, to _____, 1957, that I last saw the deceased alive on <u>Jan. 6</u> , 1959, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Philip H. Varner</u> M.D. <u>10, 620 1/2 Ave.</u> DATE SIGNED <u>1-8-59</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/10/59		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUNHEEY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE <u>Raymond J. Ziska</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

884 CERTIFICATE OF DEATH

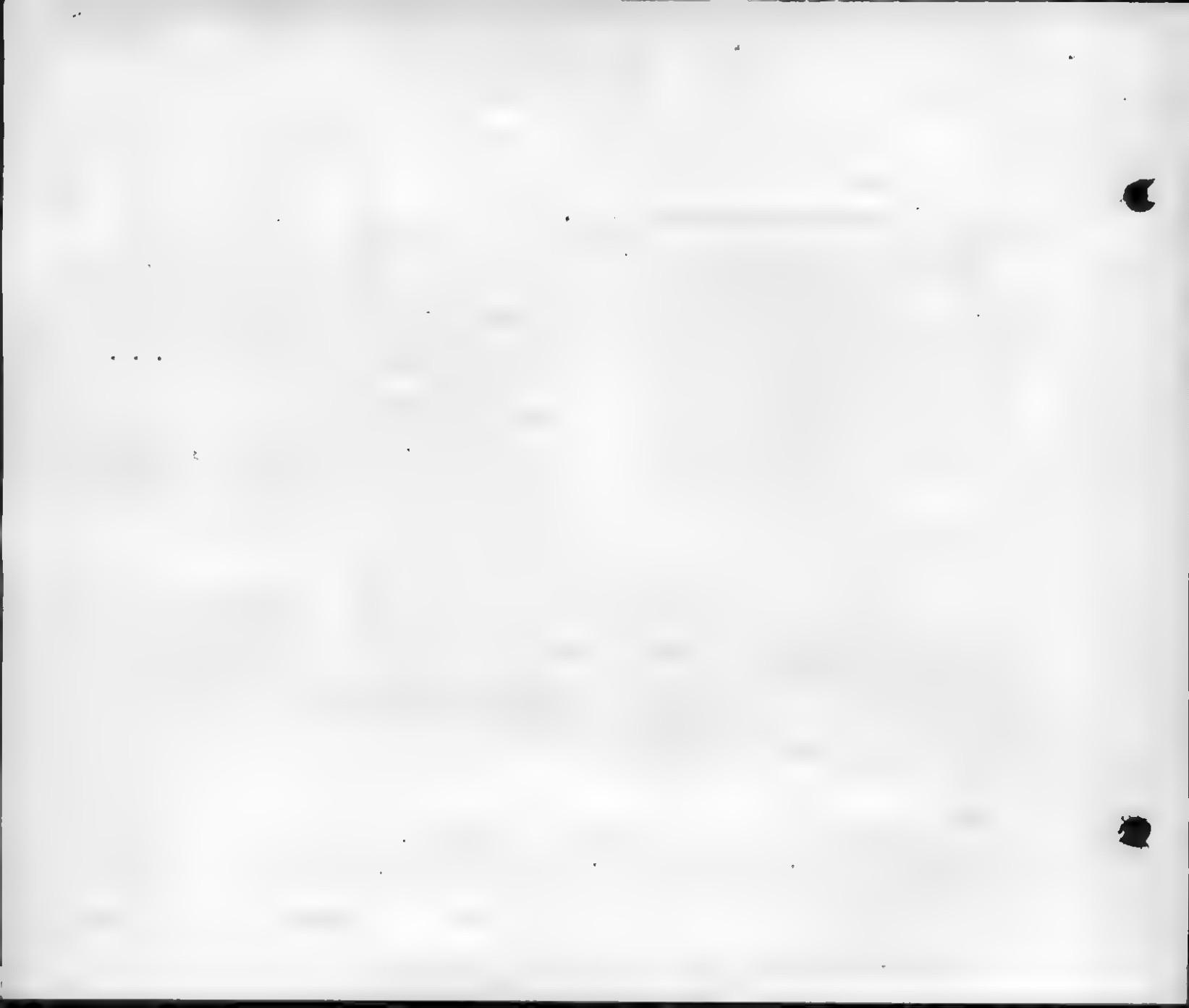
00872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 108 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scranton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 105 South 7th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Diane	Middle Marie	Last Lisak
4. DATE OF DEATH	Month January	Day 8	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1950
9. AGE (In years last birthday) 8 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Lisak		14. MOTHER'S MAIDEN NAME Anna Caranda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Intestinal obstruction			
DUE TO 756.6			
INTERVAL BETWEEN ONSET AND DEATH 18 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Undiagnosed disease of intestine		DUE TO 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 22, 1958 , to January 8, 1959 , that I last saw the deceased alive on January 8, 1959 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 1/8/59			
ACTUAL SIGNATURE <i>Eugene B. Feigelson</i>	M.D.		
PHYSICIAN'S NAME (Type) Eugene B. Feigelson, M. D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Bur-Transit 1/8/59	22b. DATE THEREOF 1/8/59	22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Scranton, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR JAN 12 '59	24b. REGISTRAR'S SIGNATURE Carrie L. Haas

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

885

CERTIFICATE OF DEATH

00873

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 3106 Kingtree Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Infant (Newborn)	First	Middle	Last	4. DATE OF DEATH Little	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 28, 1959	9. AGE (in years last birthday) yrs. 3	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Foy F. Little		14. MOTHER'S MAIDEN NAME Sylvia Belcher		Address 3106 Kingtree Street Silver Spring, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sylvia Little		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis DUE TO 1.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) Premature Separation placenta	
						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4630 Montg. Ave. Bethesda		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Michael L. Buckley M.D. 4630 Montg. Ave. Bethesda DATE SIGNED 1/28/59							
ACTUAL SIGNATURE Michael L. Buckley		PHYSICIAN'S NAME (Type) Michael L. Buckley					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Lumpkin		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 4 '59		24b. REGISTRAR'S SIGNATURE John S. Tracy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

886

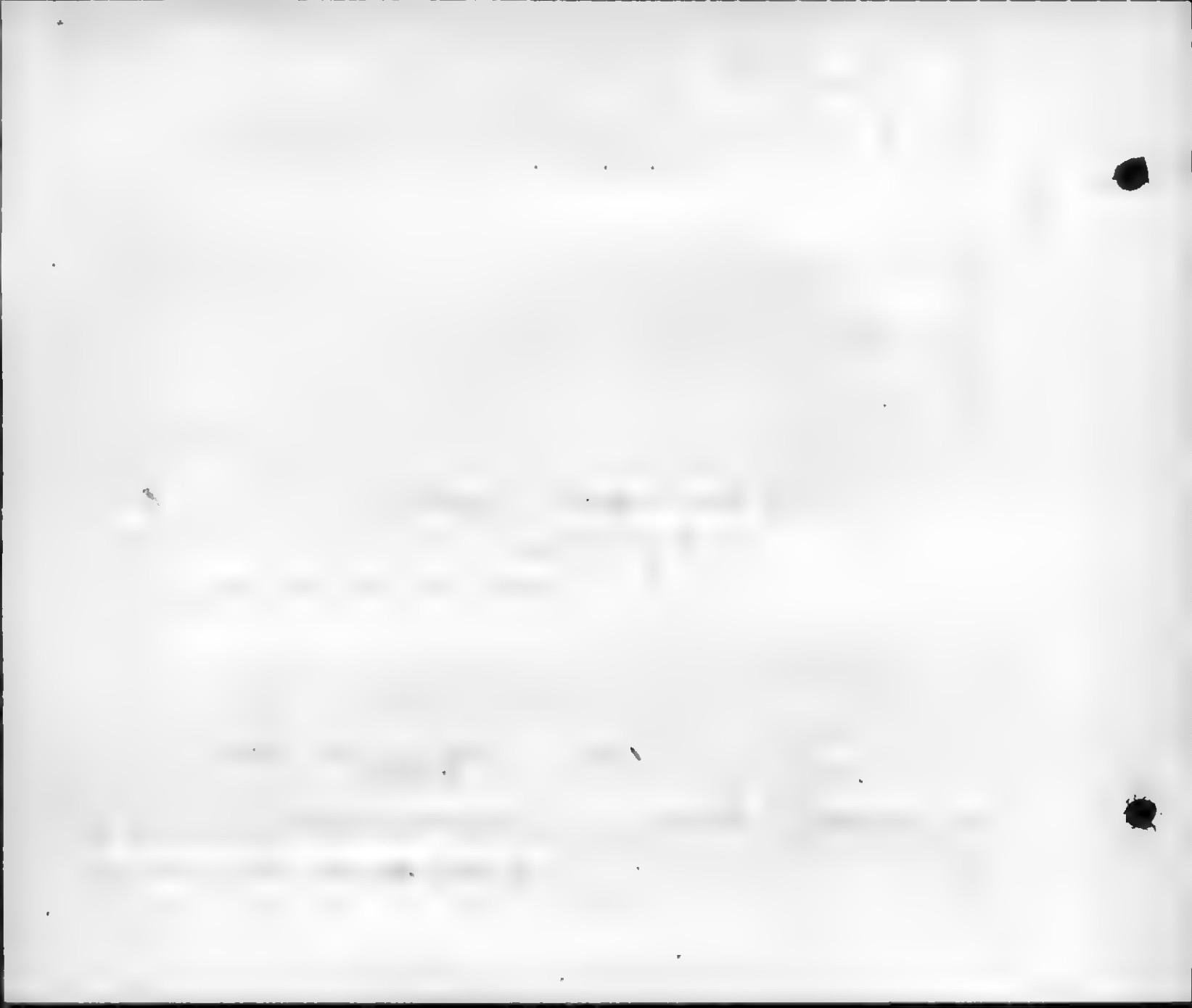
Item 2 21164 38 2-2-59 et

CERTIFICATE OF DEATH

OC874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN lb 9yr. 2mo. 12ds.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS Methodist Home Route #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Millie	Middle Ella	Last Little	4. DATE OF DEATH January 20 1959	Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH December 11, 1863	9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Matron		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rezin F. Albert		14. MOTHER'S MAIDEN NAME Hannah Backingham					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service]		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarct</i> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) <i>anterior ischemia</i> DUE TO (c) <i>hypertensive cardiovascular disease</i>							
INTERVAL BETWEEN ONSET AND DEATH -79-59							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19							
21. I certify that I attended the deceased from <u>14</u> , 19 <u>55</u> , to <u>1 - 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 - 20</u> , 19 <u>59</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>M.D. 10128 CEDAR LANE, Kensington Md 1-20-59</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Sarah E. Glover</u>							
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/59	22c. NAME OF CEMETERY OR CREMATORIUM Westminster Cemetery		22d. LOCATION (City, town, or county) Westminster, Carroll ^(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jane J. Saffell</u>		ADDRESS 254 E. Main St. Westminster, Md.		24a. REC'D BY REGISTRAR DATE 23 '59		24b. REGISTRAR'S SIGNATURE <u>Jane J. Saffell</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00875

887

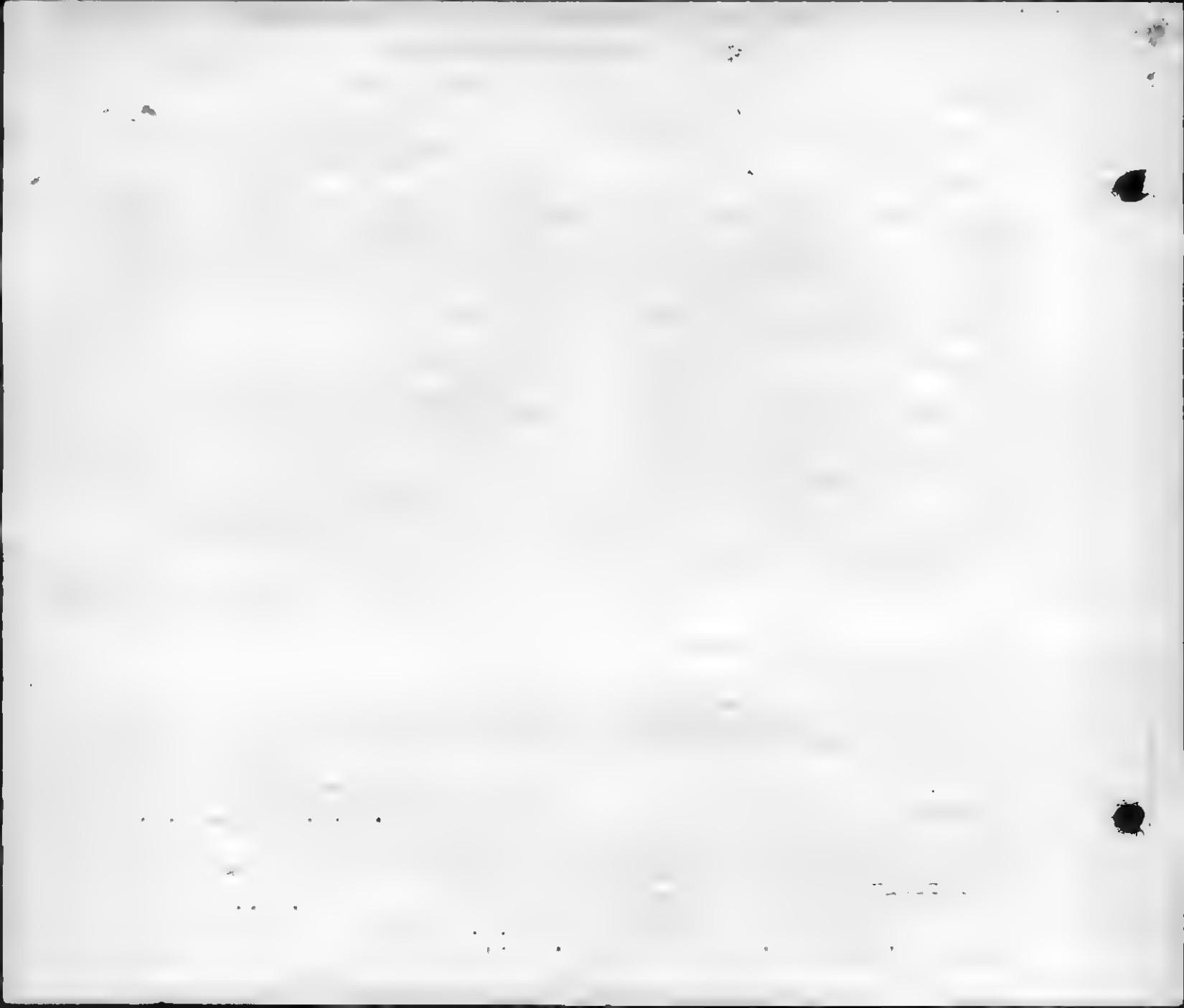
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE			
Montgomery . MARYLAND		Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
RURAL and give nearest town Bethesda.	4 yrs.	Chevy Chase.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	1d. STREET ADDRESS				
Suburban	4808 Wellington Dr.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
Victor		Samuel	Little.		
4. DATE OF DEATH	Month	Day	Year		
	Jan.	19	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 6, 1889		
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.			
70 yrs.	Months Days Hours	Months Days Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Automotive.		New York	U.S.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
John Little	Sarah Brush.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] If yes, give war or date of service]	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
yes. W.W.I.	578-05-9757	Mary Little, 4808 Wellington Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Thrombosis 5 days				
332X	DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	Cerebral Arterio sclerosis. 6 years.			
DUE TO	(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that I attended the deceased from January 14, 1959, to January 19, 1959, that I last saw the deceased alive on January 19, 1959, and that death occurred at 7:25 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)			DATE SIGNED	
ACTUAL SIGNATURE	Charles W. Humphreys, Jr. M.D. 1746 K St. N.W., Wash. D.C.				
PHYSICIAN'S NAME (Type)	Charles W. Humphreys, Jr.				
22a. BURIAL, CREMATION REMAINS burial	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)	
	1/22/59	Cedar Hill Cemetery	Pr. Geo. Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
The S.H. Hines Co., 2901 14th St. N.W.,	Wash. D.C.	JAN 21 '59	C. S. Klaus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

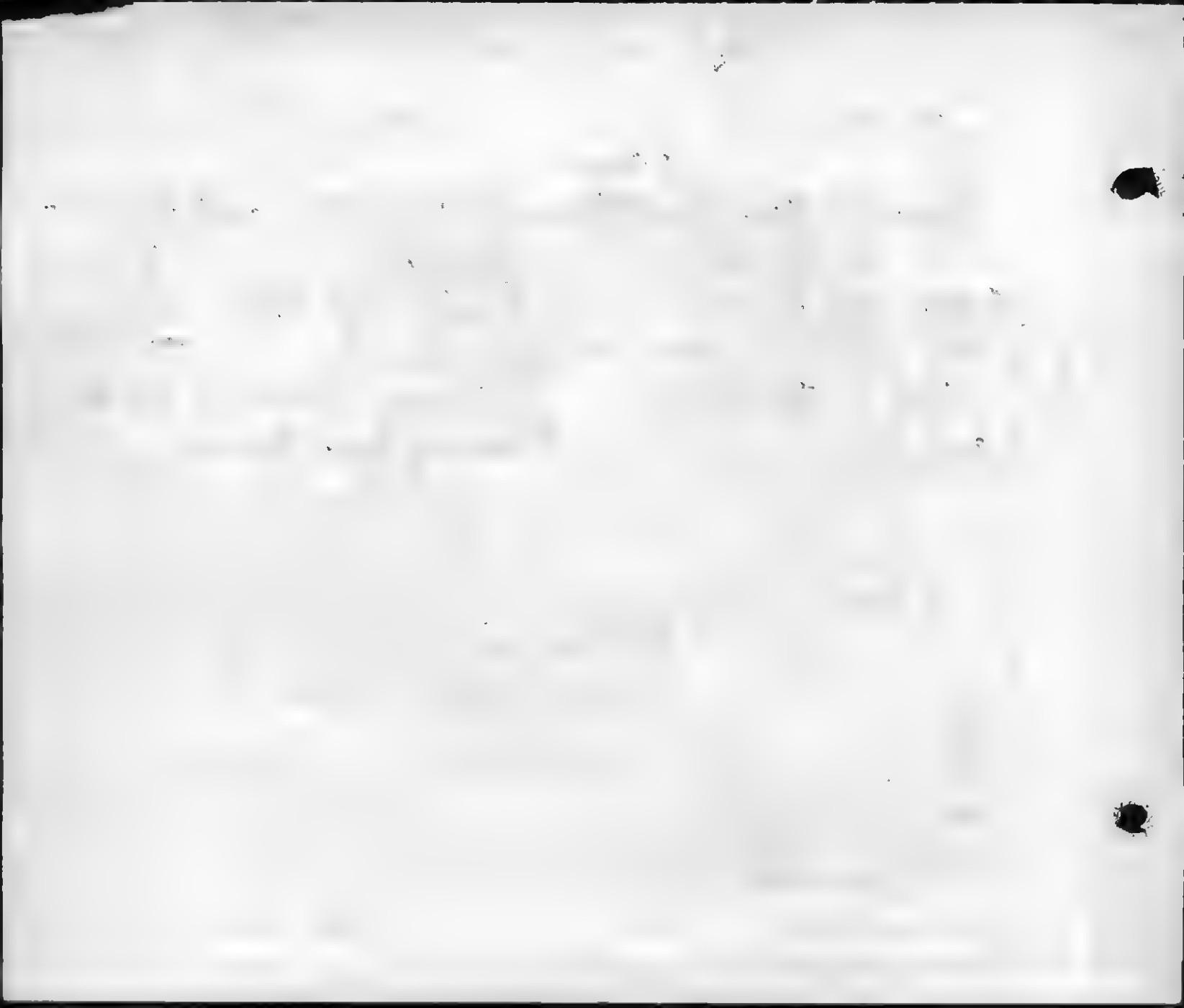
888

CERTIFICATE OF DEATH

00876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Arlington</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	c. LENGTH OF STAY IN lb <i>7 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Castell Hall Sanatorium</i>		d. STREET ADDRESS <i>1545 S. Vermont St.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>	First <i>L</i>	Middle <i>S</i>	Last <i>Floyd</i>			
4. DATE OF DEATH <i>Feb. 7-1879 79 yrs</i>	Month <i>1</i>	Day <i>3</i>	Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 7-1879 79 yrs</i>			
9. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10. b. KIND OF BUSINESS OR INDUSTRY <i>Home-making</i>	11. c. BIRTHPLACE (State or foreign country) <i>N. Y.</i>	12. d. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>			
13. FATHER'S NAME <i>John Wallace</i>	14. MOTHER'S MAIDEN NAME <i>Mary Jane McCarthy</i>	Address <i>Nursing Home Records</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>.....</i>	17. INFORMANT <i>.....</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension with chronic congestive heart failure</i>						
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p.m. p. m.	Month <i>Jan.</i>	Year <i>1959</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3000 Don't Place, N.W.</i>	(County) <i>District of Columbia</i>	(State) <i>D.C.</i>
21. I certify that I attended the deceased from <i>Dec. 27, 1958</i> , to <i>Jan. 3, 1959</i> , that I last saw the deceased alive on <i>Jan. 3, 1959</i> , and that death occurred at <i>3:20 P.M.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R. Stephen Hubbard</i>	M.D.		ADDRESS (Street, city or town, state) <i>3000 Don't Place, N.W.</i>		DATE SIGNED <i>Jan. 3, 1959</i>	
PHYSICIAN'S NAME (Type) <i>R. Stephen Hubbard</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-6-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Columbia Gardens</i>		22d. LOCATION (City, town, or county) <i>Arlington, Va.</i>	(State) <i>Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>West Funeral Home C. M. Frantz</i>	ADDRESS <i>284 Wilson Blvd. Arlington, Va.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Office of S. Kuhn</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

UC877

889

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL [REDACTED] The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>92 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selinsgrove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. STREET ADDRESS <u>907 North 8th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Karen</u>		First <u>Karen</u>	Middle <u>Sue</u>	Last <u>Luttrell</u>	4. DATE OF DEATH Month <u>January</u> Day <u>3, 1959</u>
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1956</u>		9. AGE (In years last birthday) <u>2 yrs</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Richard P. Luttrell</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Brinkley</u>		12 CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.3</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Acute Leukemia (c)				INTERVAL BETWEEN ONSET AND DEATH HOURS <u>9 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 3, 1958</u> , to <u>January 3, 1959</u> , that I last saw the deceased alive on <u>January 3, 1959</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>National Institutes of Health</u> <u>1-4-59</u> <u>Bethesda 14, Maryland</u>					
ACTUAL SIGNATURE <u>Nathan S. Taylor</u>		M.D.			
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>					
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial-transit 1-4-59</u>		22b. DATE THEREOF <u>1-4-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Lawn Croft Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Delaware County, Penna.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
				24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



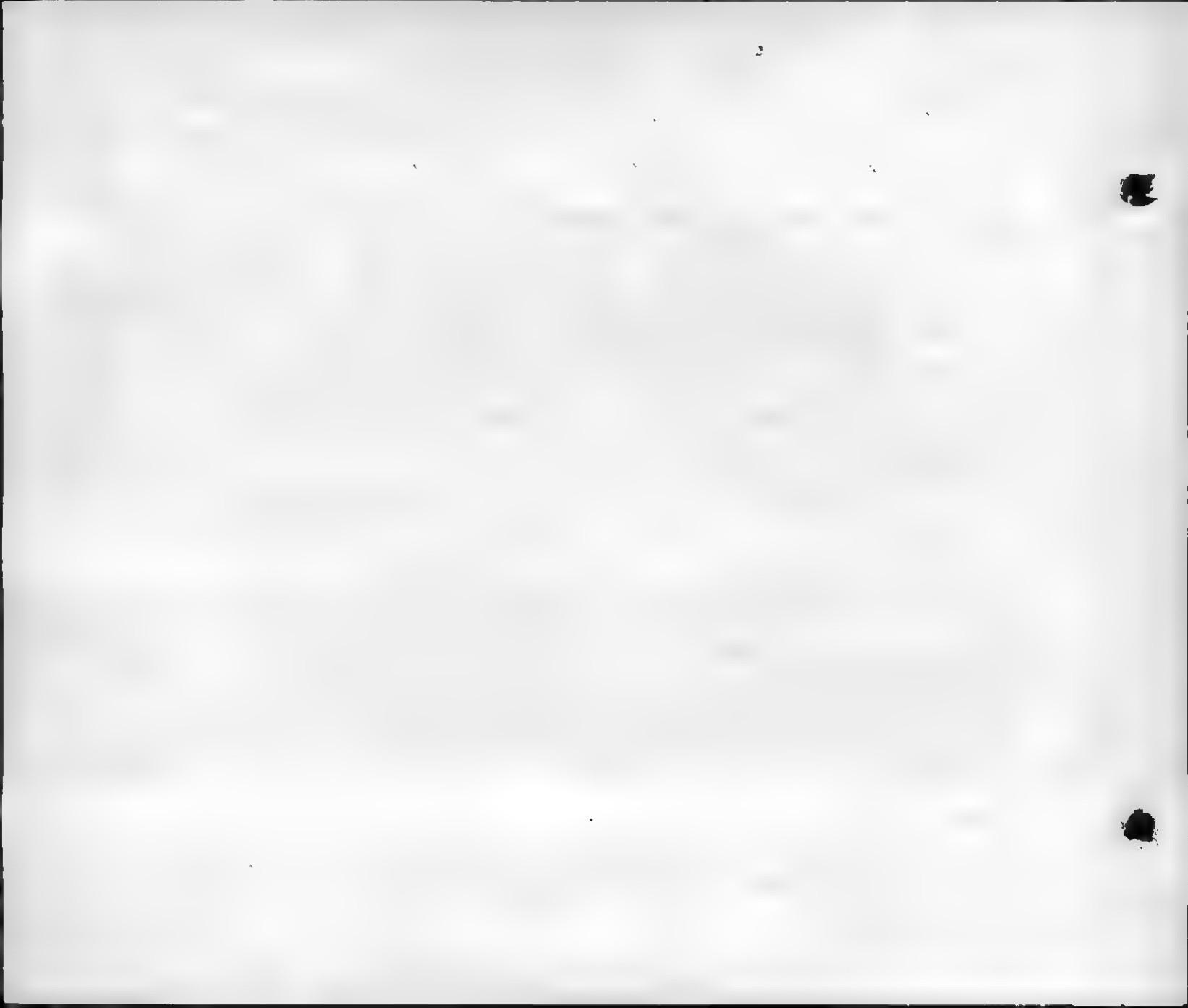
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE					
MONTGOMERY Co., MARYLAND		MARYLAND b. COUNTY River Grange					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOW. PARK.		c. LENGTH OF STAY IN b. WEEK.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle				
		Lust	4. DATE OF DEATH Month Day Year				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-27-59	9. AGE ^{in years lost/birthday} yrs. months days hours min	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD.		10b. KIND OF BUSINESS OR INDUSTRY NONE.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Robert McNamee		14. MOTHER'S MAIDEN NAME Faith Marie Kragie		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO NONE.		17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO DUE TO		AFFECTATION, FETAL TYPE. PREMATURITY		INTERVAL BETWEEN ONSET AND DEATH LIFE. LIFE.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/27 , 19 59 , to 1/28 , 19 59 , that I last saw the deceased alive on 1/28 , 19 59 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SIGNATURE Jos J. McDonald M.D. 7309 BIGGS RD. DATE SIGNED 1/28/59 PHYSICIAN'S NAME (Type) Jos J. McDonald W. HARRISVILLE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-13-57		22c. NAME OF CEMETERY OR CREMATORIAL Washington Sanitorium & Hospital		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert P. Hobbs, M.D. Washington Sanitorium & Hospital		ADDRESS 111 W. HARRISVILLE RD.		24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE John S. Flanagan	



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

00878

890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Linthicum</i>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>		c. LENGTH OF STAY IN lb <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Luke's Hospital</i>		d. STREET ADDRESS <i>1240 North Washington Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Bobby Ray Mahone</i>		First	Middle	Last	4. DATE OF DEATH <i>1-4-59</i>	Month	Day	Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-59</i>		9. AGE (In years last birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>			
13. FATHER'S NAME <i>Charles Edward Mahone</i>		14. MOTHER'S MAIDEN NAME <i>Jean Sorrell</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Planning & Initiatives</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>773.5</i>		DUE TO <i>Cardiovascular Failure</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Immobility</i>		(b)							
DUE TO <i>(c)</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Rockville</i>		(County) <i>Montgomery</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan 5, 1959</i> , to <i>Jan 5, 1959</i> , that I last saw the deceased alive on <i>Jan 5, 1959</i> , and that death occurred at <i>Rockville</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>8218 Wisconsin Ave, Bethesda, MD</i>		DATE SIGNED <i>John M. Wilson</i>							
ACTUAL SIGNATURE <i>John M. Wilson</i>									
PHYSICIAN'S NAME (Type) <i>Homer M. Wilson</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan 7 1959</i>		22b. DATE THEREOF <i>Jan 7 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Lincoln Park</i>		22d. LOCATION (City, town, or county) <i>Rockville, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>T. Scott L. Leander</i>		ADDRESS <i>Rockville Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John M. Wilson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00879

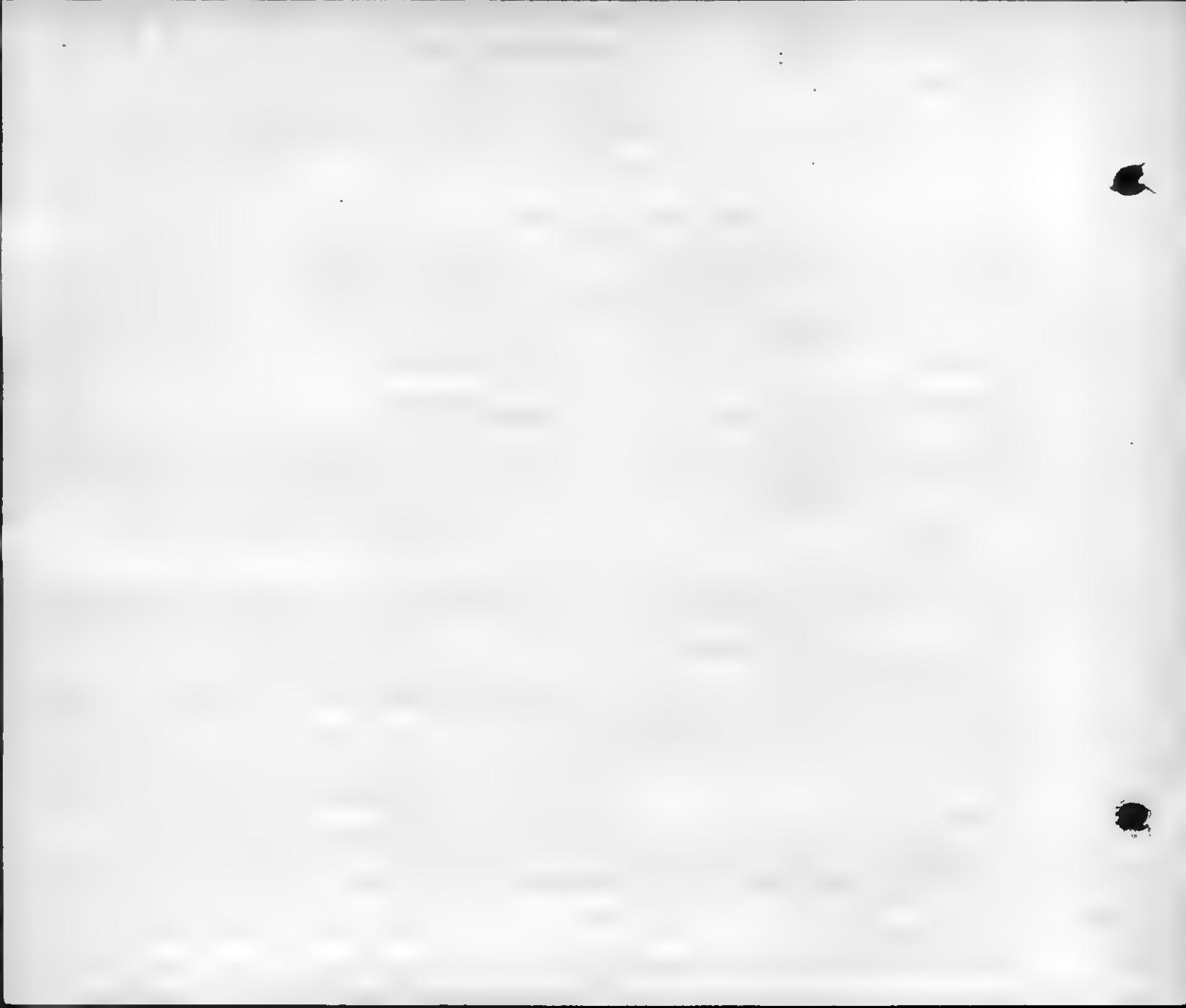
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
891 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL		<i>Theater</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>Theater</i> <i>Residence</i>	<i>1704 Alberti Road</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
LULA	G	MANUEL	JAN.
4. DATE OF DEATH	Month	Day	Year
	JAN.	4	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W		<i>June 19- 1889</i>
9. AOE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Horse wife.</i>		<i>None</i>	
10c. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>None</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>David Percy</i>		<i>Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		<i>Donald L. Manuel</i> <i>1704 Alberti Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Generalized carcinomatosis</i> <i>3 years</i>	
175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b)		<i>adenocarcinoma of breast</i>	
DUE TO (c)		<i>origin</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1</i> , 1958, to <i>Jan 4</i> , 1959, that I last saw the deceased alive on <i>Jan 1st</i> , 1959, and that death occurred at <i>6309</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>FRANK L. WILLIAMS</i> <i>2731</i> M.D.	
ACTUAL SIGNATURE <i>Frank L. Williams</i>		DATE SIGNED <i>1/4/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial Jan 7-1959</i>		<i>Dec. 1st Cemetery Ridge Road - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Editha Miller 254 Carroll St N.B.</i>		24a. REC'D BY REGISTRAR DATE <i>Jan 7 1959</i>	
		24b. REGISTRAR'S SIGNATURE <i>Editha Miller</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00860

892

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. **Loge 4**
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 807 North Columbus Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carl		First	Middle Eugene	Last Marks	4. DATE OF DEATH January 7, 1959	Month January	Day 7	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 30, 1958		9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS Days 8	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Herbert J. Marks				14. MOTHER'S MAIDEN NAME Elizabeth L. Winston				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral severe pulmonary atelectasis & pneumonia 2 mos</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Congenital heart disease, ventricular septal defect 4 mos</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 4, 1959 , to January 7, 1959 , that I last saw the deceased alive on January 7, 1959 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Robert D. Bloodwell</i>		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED National Institutes of Health 1-8-59 Bethesda 14, Maryland						
PHYSICIAN'S NAME (Type) Robert D. Bloodwell, M. D.								
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	22b. DATE THEREOF 1-10-59	22c. NAME OF CEMETERY OR CREMATORIUM Bethel		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Leroy Cunningham</i>		ADDRESS Cameron & Alfred S. Cunningham Funeral Home Inc.		24a. REC'D BY REGISTRAR JAN 12 '59	24b. REGISTRAR'S SIGNATURE <i>C. G. J. 1/12/59</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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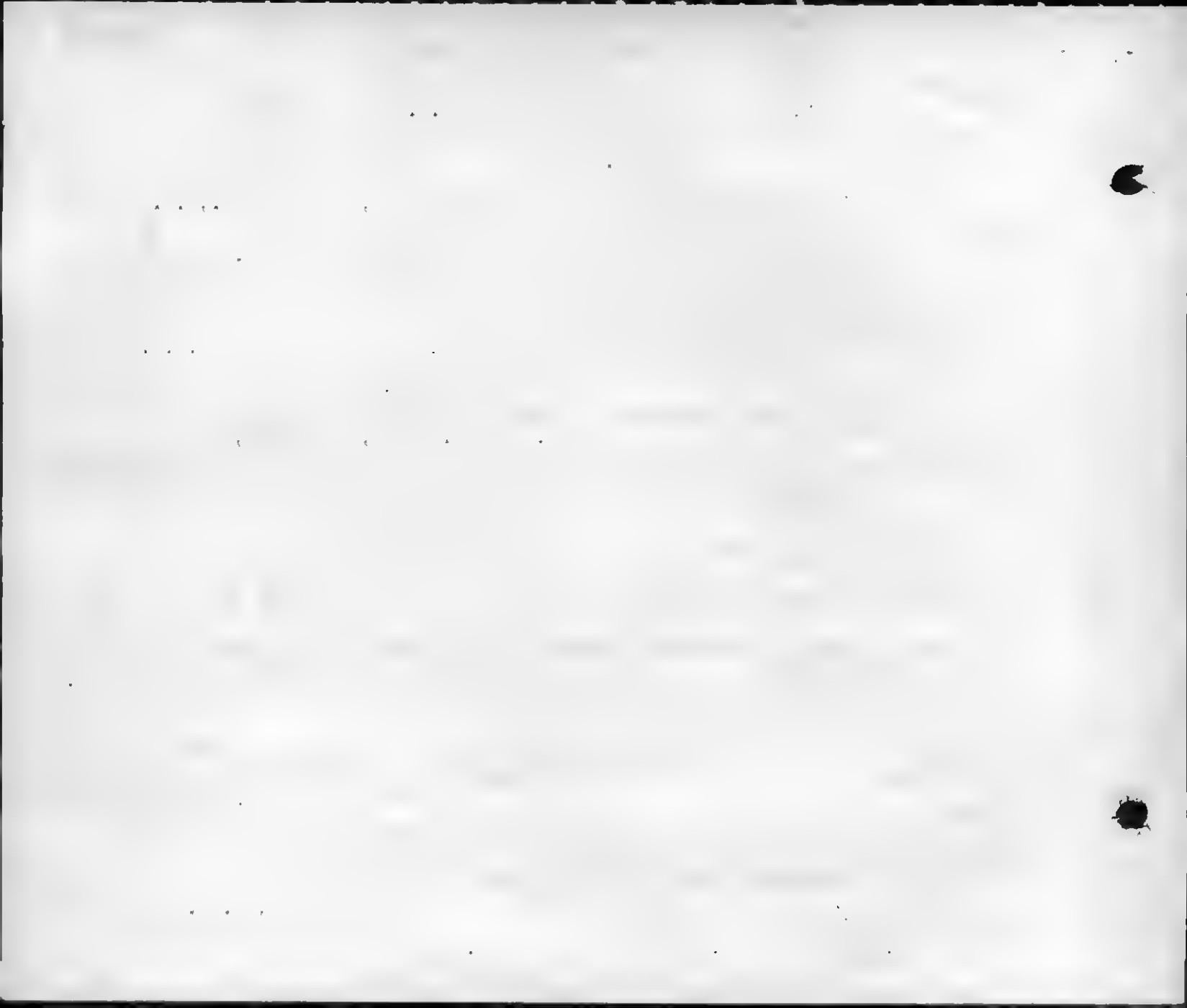
CERTIFICATE OF DEATH

Reg. Dist. No.

UC881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE D.C. b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 4-1									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WAVERLY SANITARIUM		d. STREET ADDRESS Chatham Courts, Columbia Rd., N.W.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)	First LOUISE	Middle GIDDINGS	Last MARTIN								
4. DATE OF DEATH	JAN.	Month JAN.	Day 17	Year 1959							
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/66	9. AGE (In years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Glenville		14. MOTHER'S MAIDEN NAME Dorcas Hempston									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John R. Clark, White Oak, Maryland		Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 12 hours							
(b) DUE TO		GENERALISATION OF ARTERIAL DISEASES		8-10 years							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1959, to January 17, 1959, that I last saw the deceased alive on January 17, 1959, and that death occurred at 3:15 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.		DATE SIGNED 1/17/59	
ACTUAL SIGNATURE W.B. WARDROP M.D.		PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORIY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. FUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D. BY REGISTRAR JAN 21 '59		24b. REGISTRAR'S SIGNATURE C. L. Kraus					
Raymond J. Gisean				DATE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

776

CERTIFICATE OF DEATH

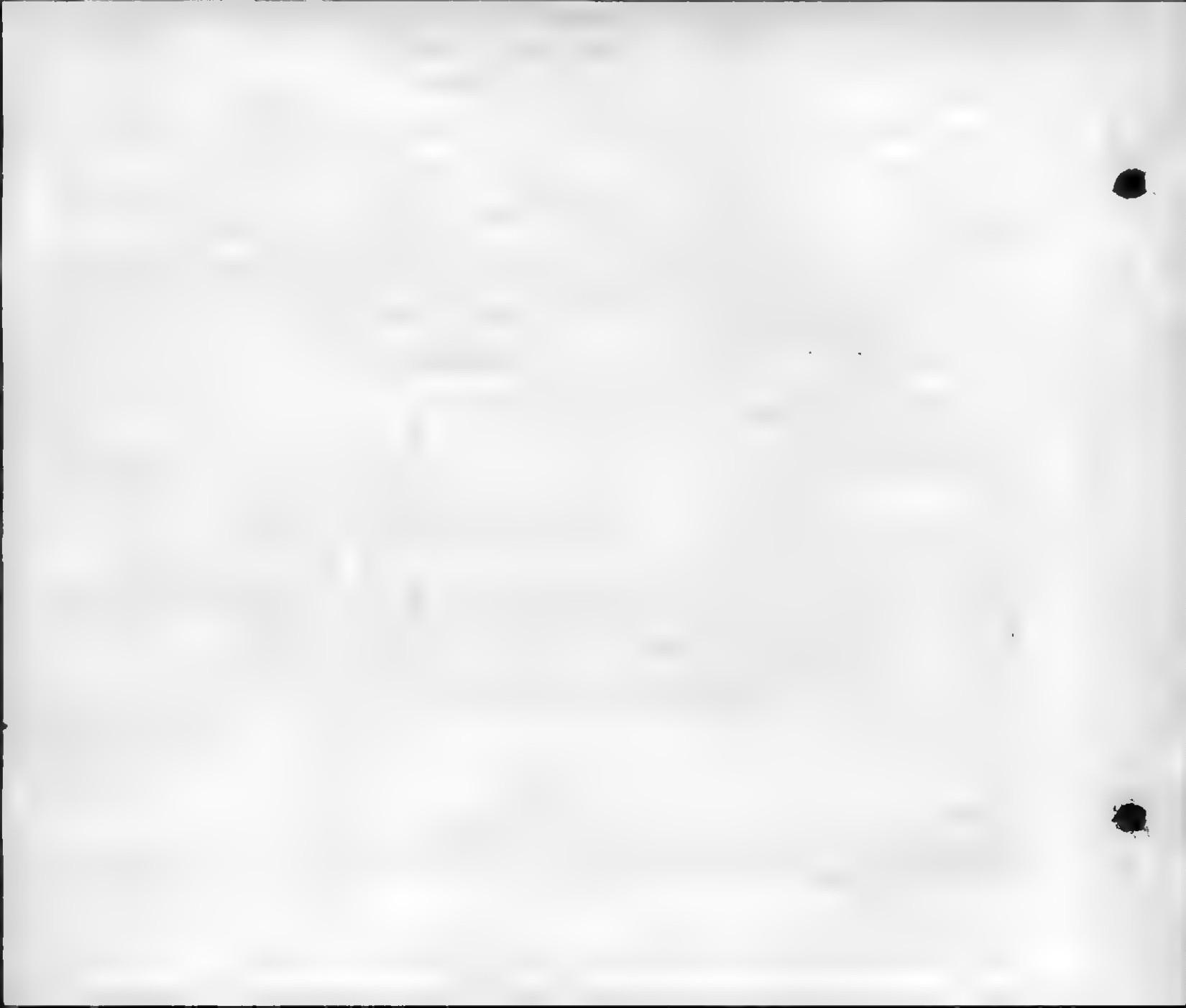
Reg. Dist. No.

00882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH • COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b <i>1 month</i>	b. COUNTY <i>M.D.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital</i>		d. STREET ADDRESS <i>17-01 Takoma Park</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Walnut</i>	Last <i>McCabe</i>
4. DATE OF DEATH	Month <i>Jan</i>	Day <i>17</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-78</i>
9. AGE (In years last birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>American</i>
13. FATHER'S NAME <i>Charles Walnut</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Taylor</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>It's exact</i>	Address <i>-</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hr</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost (b) <i>inflammation</i>		DUE TO <i>inflammation</i>	
(c) <i>coronary thrombosis</i>		DUE TO <i>inflammation</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>July</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>July 10, 1959</i> to <i>July 11, 1959</i> , that I last saw the deceased alive on <i>July 10, 1959</i> , and that death occurred at <i>1857 Carroll St</i> , M.D., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur Walter</i>		ADDRESS (Street, city or town, state) <i>1857 Carroll St</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>1857 Carroll St</i>	
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 21, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Laurel Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Philadelphia, Pennsylvania</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walter</i>	ADDRESS <i>254 Carroll St NW DC</i>	24a. REC'D BY REGISTRAR <i>Jan 21 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur Walter</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

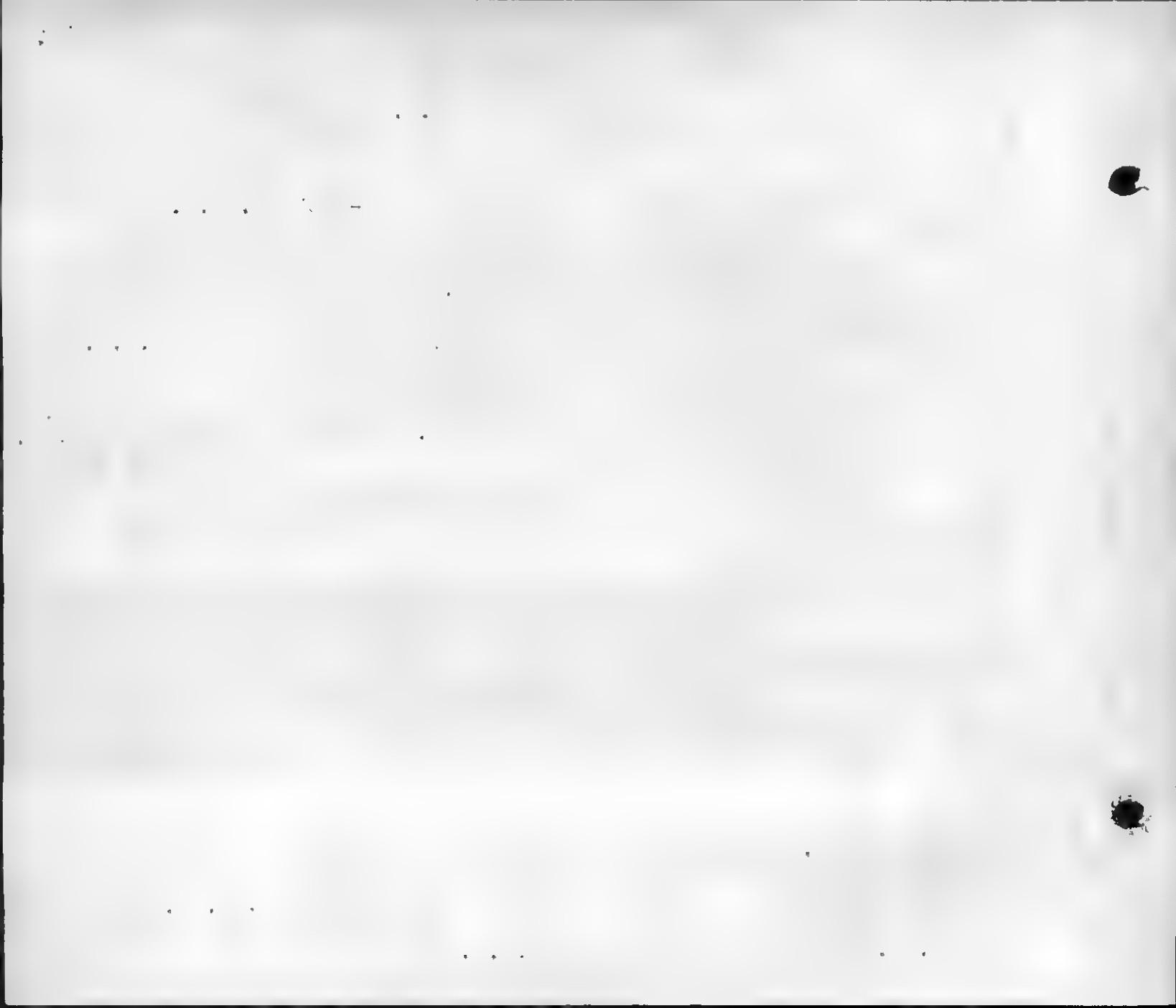
893

CERTIFICATE OF DEATH

UC883

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORENCE	Middle M	Last McKEEVER
4. DATE OF DEATH	Month 1	Day 1	Year 1859
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1876
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ionia, Michigan	
11. BIRTHPLACE (State or foreign country) Ionia, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Franklin Spencer		14. MOTHER'S MAIDEN NAME Sarah Kidd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Margaret M. Brumbaugh	
17. INFORMANT Margaret M. Brumbaugh		Address 4309 Elm St. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF BLADDER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 57 , to Jan. 1 , 19 59 , that I last saw the deceased alive on January 1, 1959 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE James M. Loftus M.D.		ADDRESS (Street, city or town, state) 1673 PARK Road N.W. Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/59	
22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company Washington, D.C.		24a. REC'D BY REGISTRAR DATE JAN 3 '59	
		24b. REGISTRAR'S SIGNATURE James M. Loftus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

894

CERTIFICATE OF DEATH

Reg. Dist. No.

00884

1		PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania		b. COUNTY	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McSherrystown			
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUTION The Clinical Center				d. STREET ADDRESS 123 2nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Joseph		Middle Grover		Last McKinney		4. DATE OF DEATH January 4, 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1884		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker		10b. KIND OF BUSINESS OR INDUSTRY Cigar Manufacturer		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY: U. S. A.			
13. FATHER'S NAME Joseph McKinney		14. MOTHER'S MAIDEN NAME Margaret Martin							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		DUE TO 2040		INTERVAL BETWEEN ONSET AND DEATH 1					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last { (b) _____ DUE TO (c) _____		G. I. Bleeding		2					
G. I. Bleeding		Chronic Lymphatic Leukemia		3					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 1, 1959 to January 4, 1959 that I last saw the deceased alive on January 4, 1959 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. M. Marsh, M.D.</i>		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 8 1959		22b. DATE THEREOF st Mary		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Mc Gregor & Adams Bldg.			
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Marsh, M.D. Mc Gregor & Adams		ADDRESS 2nd Floor, 123 2nd Street, Bethesda 14, Maryland		24a. REC'D BY REGISTRAR Jan 13 1959		24b. REGISTRAR'S SIGNATURE Carroll & Keane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10W
The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

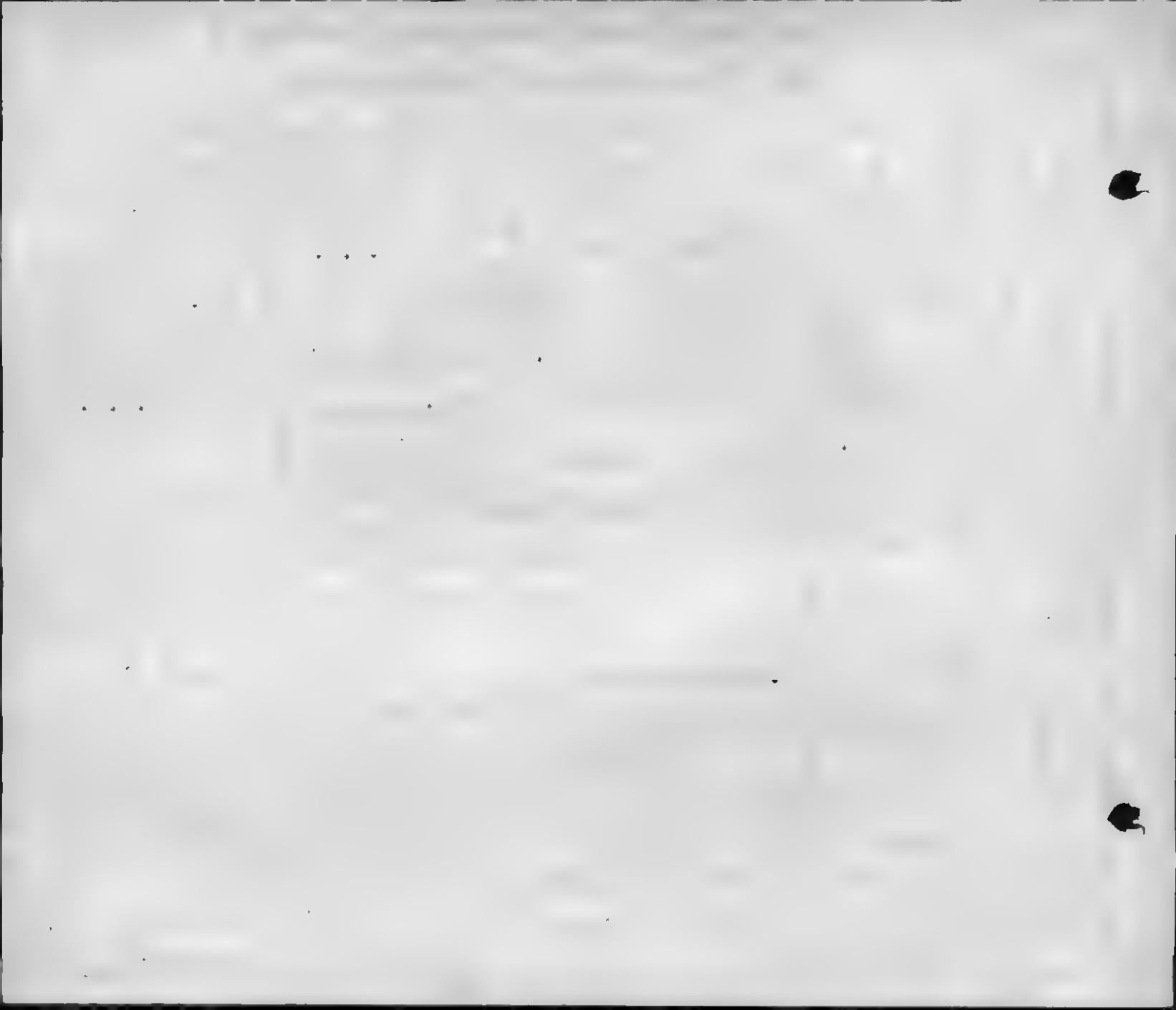
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CC885

895 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN Ashton)		MARYLAND LENGTH OF STAY (In this place) 4 Days	STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg		(If rural give location) R.F.D. 2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belmont Nursing Home			STREET ADDRESS		
3. NAME OF DECEASED (First) John (Middle) Edward (Last) McMahon			4. DATE (Month) Jan. (Day) 2 (Year) 1959		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 21 1871	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME John E. McMahon			14. MOTHER'S MAIDEN NAME Valeria Pugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 217 03 7699		17. INFORMANT & ADDRESS Mabel Arnold Same As 2		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Cerebral Nephritis ANTECEDENT CAUSE(S) DUE TO (B) Arteria Sclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Insomnia					
INTERVAL BETWEEN ONSET AND DEATH years years 8 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) White Not while at work		21c. WHERE DID INJURY OCCUR? (City or town) (County) Baltimore (State) Md.	
21d. TIME OF INJURY (Month) Dec. (Day) 1959 (Year) 1959 (Hour) 10	21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> at work				
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 10/29/1958 to 10/2/1959 , that I last saw the deceased alive on 10/2/1959 , and that death occurred at 6 A.M. from the causes and on the date stated above. SIGNATURE A. J. Barber ADDRESS Santa Fe DATE SIGNED 10/4/59					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Jan. 6 1959	NAME OF CEMETERY OR CREMATORIUM Forrest Oak	LOCATION (City, town, or county) Gaithersburg Md.		
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Royce Barber Laytonsville, Md.			
DATE JAN 1 1959					



00885

**FOR STATE
HEALTH DEPT.**

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 20b&e Film 5-11-59-59
895

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]		Reg. Dist. No.	
<i>Montgomery</i>		b. STATE <i>D.C.</i>		b. COUNTY	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]		c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Washington</i>	
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address] <i>Suburban</i>		d. STREET ADDRESS <i>1610 Park Road N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret Theresa McPhee</i>		First	Middle	4. DATE OF DEATH <i>Sept. 25 1874</i>	Month <i>J</i> Year <i>1859</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 25 1874</i>	9. AGE [in years last birthday] <i>74</i> YES.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <i>buyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing Industry</i>		11. BIRTHPLACE [State or foreign country] <i>Maine</i>	
13. FATHER'S NAME <i>Daniel McPhee</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>578-07-0835A</i>		17. INFORMANT <i>Delia E. Hessian, 1610 Park Road N.W.</i>	
Address <i>Wash. D.C.</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>					
704.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture of left hip following</i>					
(c) <i>operative procedure</i> 6 days 1 hr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18] <i>Fallen on floor after entering Woodward & Lothrop's downtown store, D.C.</i>			
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. /12-30 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <i>Hotel Store Washington DC.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D.		DATE SIGNED <i>1-5-59</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		22f. DATE THEREOF <i>1/7/59</i>		22g. NAME OF CEMETERY OR CREMATORIUM <i>Calvary Cemetery</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. ADDRESS <i>2901 14th St. N.W.</i>		24b. LOCATION (City, town, or county) <i>Portland, Maine</i>	
				24c. REC'D BY REGISTRAR DATE <i>1-8-59</i>	
				24d. REGISTRAR'S SIGNATURE DATE <i>1-8-59</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

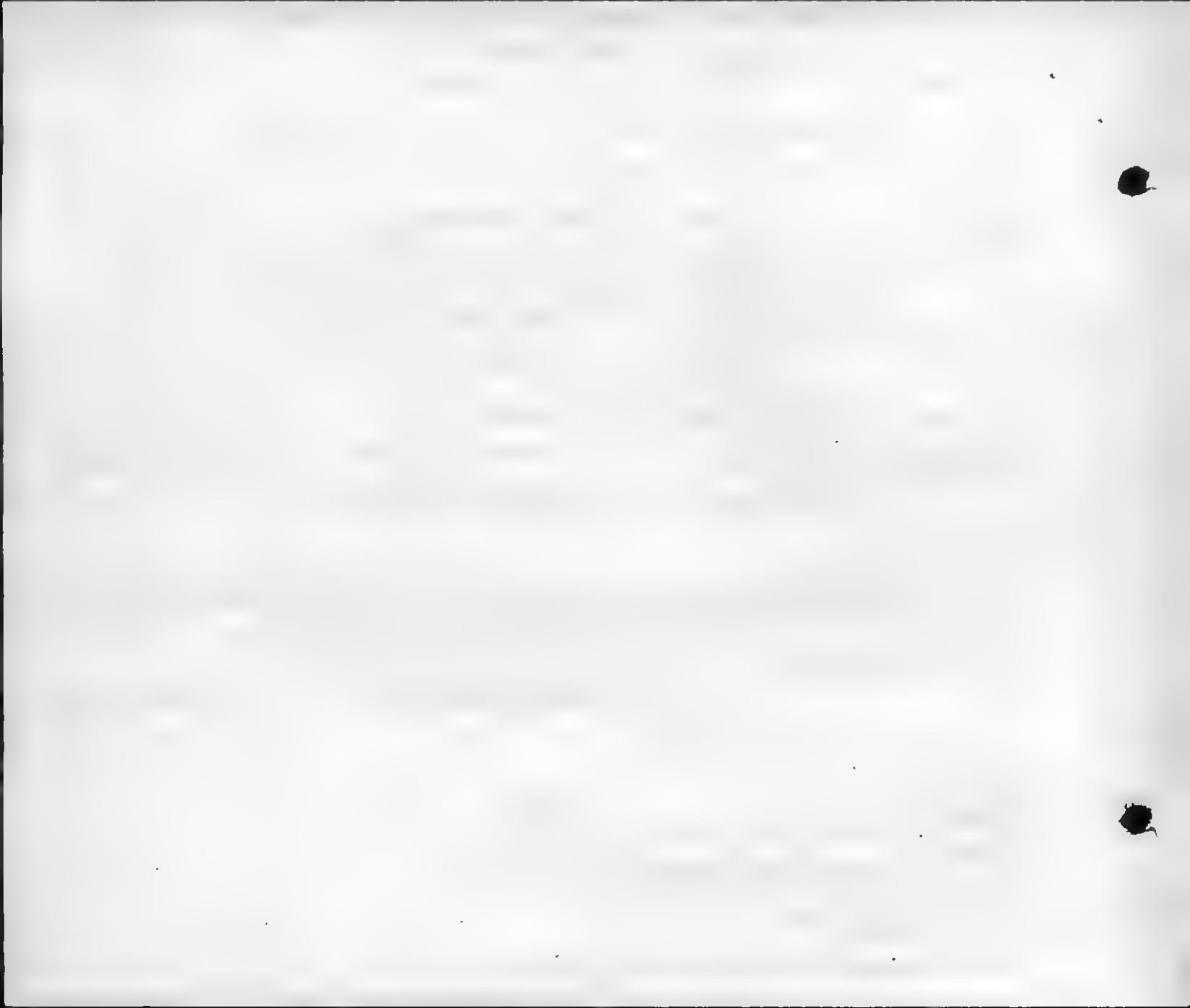
CERTIFICATE OF DEATH

Reg. Dist. No.

00887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		District of Columbia		b. COUNTY			
District of Columbia		41		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		District of Columbia		D. STREET ADDRESS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		3. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3. LENGTH OF STAY IN 1b		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
District of Columbia		1 week		District of Columbia		333 7th Street, N.W.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		District of Columbia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH		Month Day Year			
3. NAME OF DECEASED (Type or print)		First Joseph Middle Herman Last Meyers		f. DATE OF DEATH		Month 1		Day 31 Year 1959			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 27 Hours 0 Min.	
m		W		W		11/11/1876		82 yrs.		27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Ecencyman		Business		Baltimore, Maryland		American					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
John W. Myers		Elizabeth Adams		No		212-19-403		Mrs. John W. Myers			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days					
491X		DUE TO		Cerebral hemorrhage		3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19		Not while at work <input type="checkbox"/>		Baltimore, Maryland		Baltimore		Baltimore		Maryland	
21. I certify that I attended the deceased from 6:30 a.m. to 10 a.m. on 29 Jan. 1959, that I last saw the deceased alive on 29 Jan. 1959, and that death occurred at 5:55 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE		Herman C. Meier, M.D.		Herman C. Meier, M.D.		1111 Marshall Street					
PHYSICIAN'S NAME (Type)		Herman C. Meier, M.D.		Herman C. Meier, M.D.		Rockville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		2-3-59		New Cathedral Cemetery		Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey, Bethesda, Md.				FEB 4 '59		J. L. Smith					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

897

CERTIFICATE OF DEATH

Reg. Dist. No.

00888

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 733 Jefferson Street, N.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First George	Middle Ernest	Last Milburn, III	4. DATE OF DEATH January 15, 1959
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1948	9. AGE (In years last birthday) 10 yes	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS Hours 10
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME George E. Milburn, Jr.	14. MOTHER'S MAIDEN NAME Gertrude Rivkin
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Tumor of the Midbrain DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
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20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) None	(County) None	(State) None
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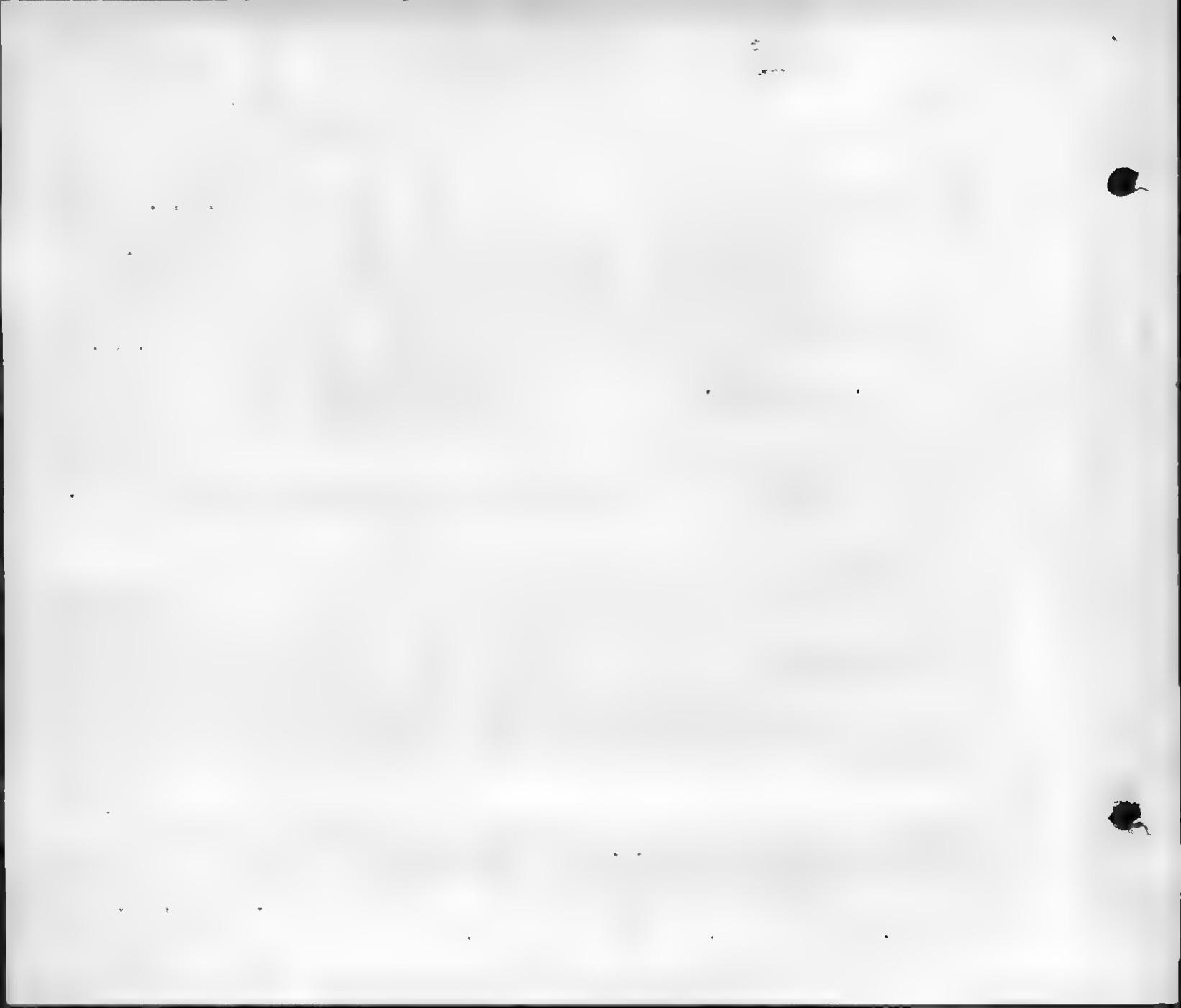
21. I certify that I attended the deceased from January 13, 1959 to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center					
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DATE SIGNED
1/15/59

ACTUAL SIGNATURE Charles A. Bucknam	M.D.	National Institutes of Health Bethesda 14, Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 1/16/59	22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL	22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.
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23. FUNERAL DIRECTOR'S SIGNATURE E. F. FLEMREY, INC.	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE JAN 19 '59	24b. REGISTRAR'S SIGNATURE Raymond J. Busha
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-institution permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

898

CERTIFICATE OF DEATH

00889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>13 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>102 Line, 15th & East</i>	d. STREET ADDRESS <i>102 Line St., Block, etc.</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Zoe</i>	Middle <i>Elizabeth</i>	Last <i>Miller</i>
4. DATE OF DEATH Year <i>Jan. 4 1959</i>	Month <i>Jan.</i>	Day <i>4</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 2 1883</i>
9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>-</i>	11. IF UNDER 24 HRS Days <i>-</i>	12. IF UNDER 24 HRS Hours <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife, seamstress, cleaner, maid</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife, seamstress, cleaner, maid</i>	
11. BIRTHPLACE (State or foreign country) <i>Charleston, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John William Pickney</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>	
17. INFORMANT (Relationship) <i>Mrs. Gail P. Bankhead</i>		Address <i>19241 Col. Blvd Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>420.0</i> (b) <i>Coronary occlusion, heart disease</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>74 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>-</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Waterville, N.Y.</i>	
21. I certify that I attended the deceased from <i>Jan. 3, 1959</i> to <i>Jan. 4, 1959</i> , that I last saw the deceased alive on <i>Jan. 3, 1959</i> , and that death occurred at <i>942 P. ADDRESS (Street, city or town, state)</i> <i>DATE SIGNED</i> <i>19241 Col. Blvd Silver Spring, Md.</i> <i>1959</i>			
ACTUAL SIGNATURE <i>J. Marion Bankhead, M.D.</i>		PHYSICIAN'S NAME (Type) <i>J. Marion Bankhead</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1-7-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>WASH</i>		22d. LOCATION (City, town, or county) <i>WATERVILLE, N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin W. Hysong, Jr.</i>		ADDRESS <i>1300-N ST. N.W., D.C.</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 6 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Marion S. Evans</i>	



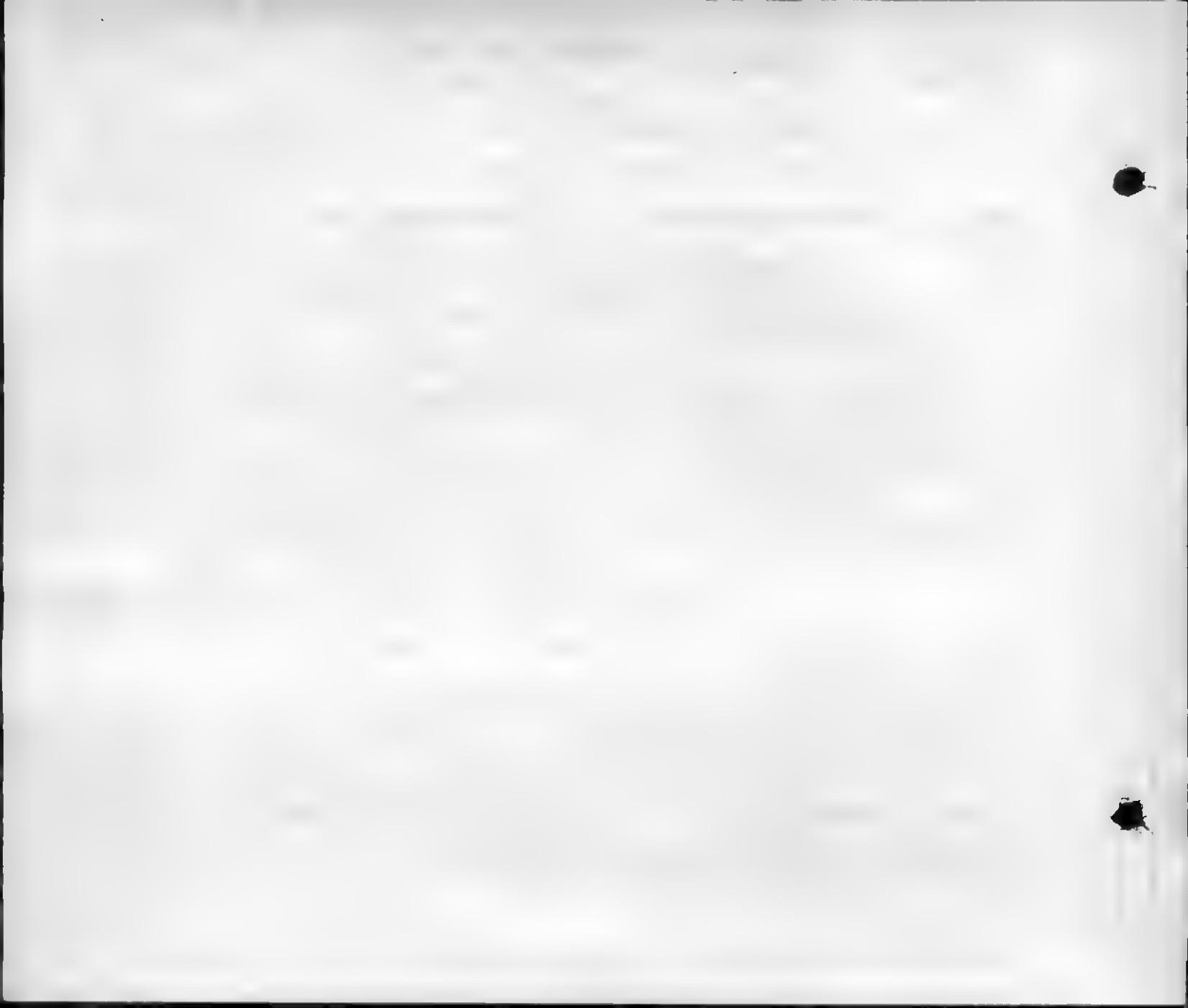
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Mo. San		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 6301-16th St NW		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mollie	Middle	Last Moldawer
4. DATE OF DEATH Jan 6-1959	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15-1895
9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max HARRIS		14. MOTHER'S MAIDEN NAME Jamie SHERBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 519-50-59 INFORMANT Address	
17. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b), AND THE DUE TO (c)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO (b) Carcinoma of R. ureter DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20a. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1959, to Jan 6, 1959, that I last saw the deceased alive on Jan 5, 1959, and that death occurred at 7:50 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Samuel Dessoff M.D. 1302-1880 N. Wash. Dr. 1/6/59			
PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		22a. BURIAL, CREMATION, OR REMOVAL (Specify) 22b. DATE THEREOF 1/8/59	
22c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Goldkey Funeral Home 4217-Gedsm		24a. REC'D BY REGISTRAR DATE JAN 8 '59	
		24b. REGISTRAR'S SIGNATURE C. L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06891

900

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE			
<i>Montgomery</i>		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 16 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9502 Saybrook Avenue		e. STREET ADDRESS 9502 Saybrook Avenue			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>Albert</i>		
4. DATE OF DEATH		Month <i>January</i>	Day Year <i>17 1959</i>		
5. SEX		6. COLOR OR RACE <i>Male</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs <i>May 2, 1909 49</i>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Isaac J. Moore</i>		14. MOTHER'S MAIDEN NAME <i>Susan Miles</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>573-03-8778</i>			
17. INFORMANT <i>Bessie Schrider</i>		Address <i>Silver Spring, Md., 9502 Saybrook Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral and pulmonary edema</i> <i>Chronic glomerular nephritis (intercapillary glomerulonephritis)</i> <i>Diabetes mellitus</i> <i>19 years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>18 Dec 1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1150 Connecticut Ave N.W. Washington D.C.</i>	20f. (City or town) <i>(County)</i>	(State)
21. I certify that I attended the deceased from <i>Dec 20, 1958</i> , to <i>Jan 17, 1959</i> , that I last saw the deceased alive on <i>Jan 17, 1959</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>E. CLARENCE RICE M.D. 1150 Connecticut Ave N.W. Washington D.C.</i>					
ACTUAL SIGNATURE <i>E. Clarence Rice</i>		DATE SIGNED <i>1/17/59</i>			
PHYSICIAN'S NAME (Type) <i>E. CLARENCE RICE</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>1/20/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>BURTONSVILLE UNION CEMETERY</i>	22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MD.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D. BY REGISTRAR <i>JAN 21 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Albert S. Kline</i>	DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

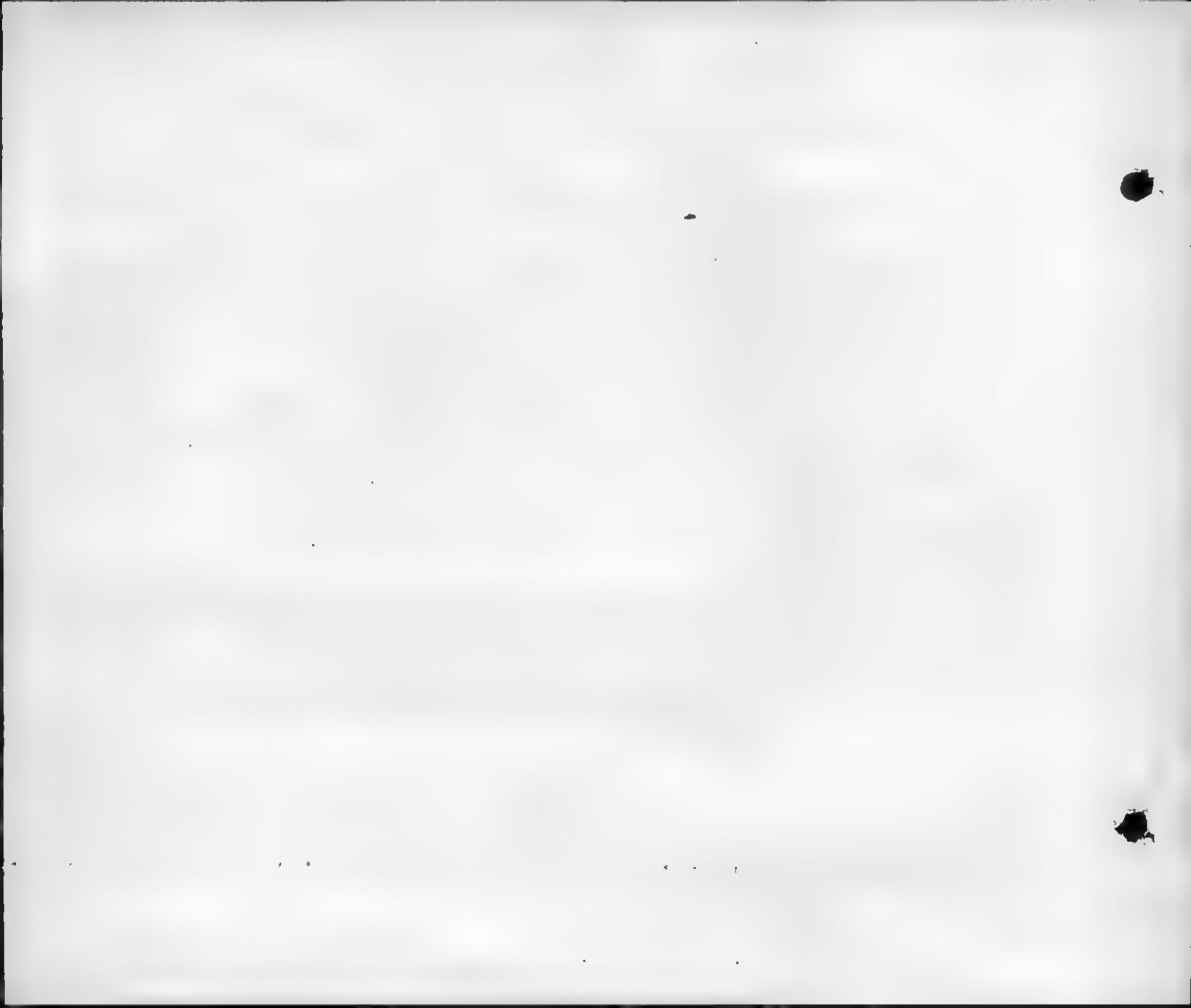
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

901

CERTIFICATE OF DEATH

Reg. Dist. No. *CC892*

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland		b COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 13801 Colesville Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First William	Middle M.	Last Moore	4. DATE OF DEATH 1/12/59	Month Day Year 19				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 25, 1877	9. AGE (In years lost birthday) 81 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Moore		14. MOTHER'S MAIDEN NAME Lucia Ball							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Carl Moore		Address 422 Lismore St. Sil. Sp., Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		445X <i>Stroke</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) <i>Hypertension</i> <i>Cardiovascular Disease</i>							
		DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 31, 1958 , to January 12, 1959 , that I last saw the deceased alive on January 11, 1959 , and that death occurred at 3:30 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1019 University Blvd. Silver Spring, Md. DATE SIGNED 1/12/59							
ACTUAL SIGNATURE Boris Rabkin									
PHYSICIAN'S NAME (Type) Boris Rabkin, M.D.		1019 University Blvd., Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co. 300-4th St. N.E. Wash		ADDRESS D.C. 20003		24a. REC'D BY REGISTRAR JAN 15 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Trahan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00893

902

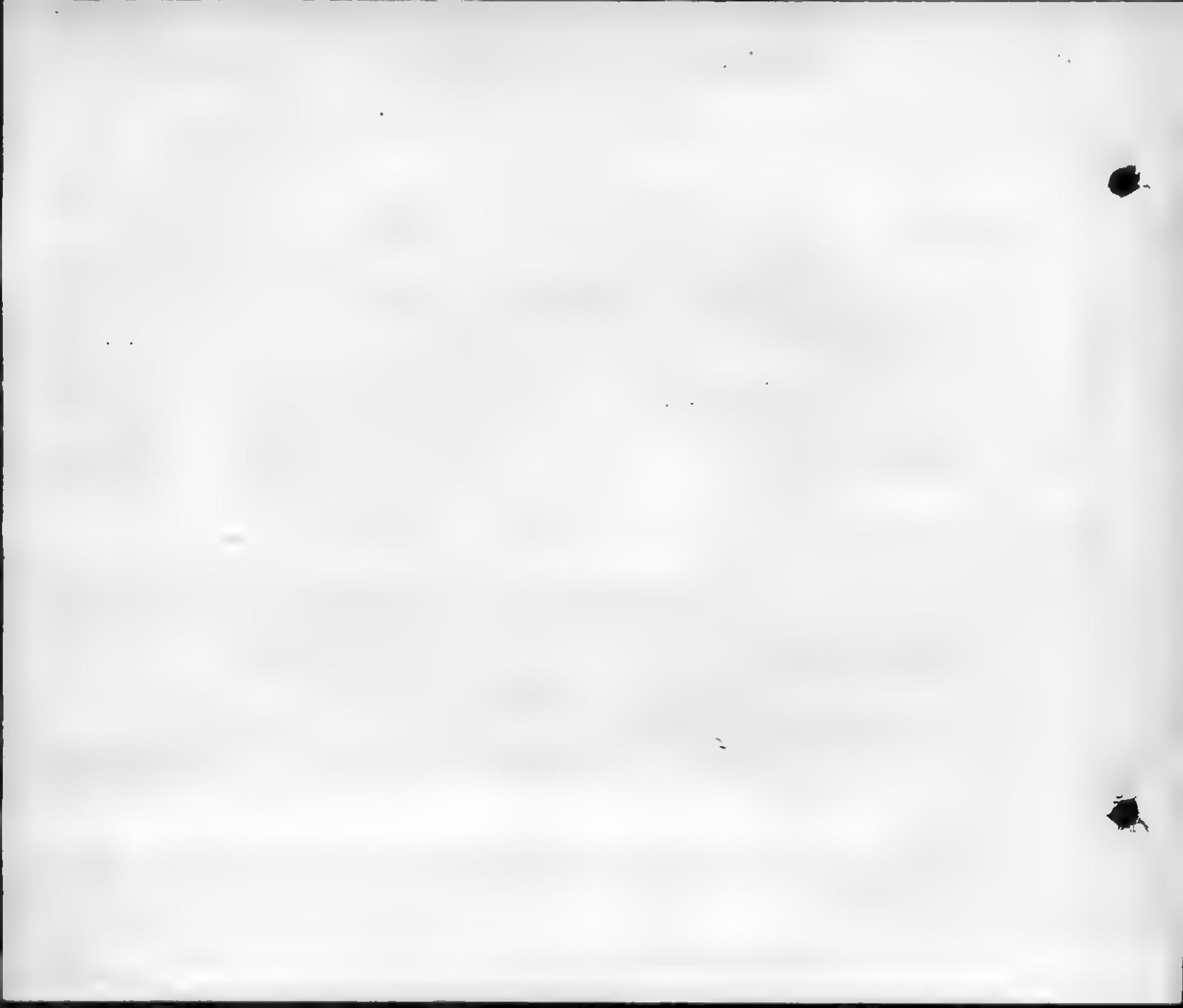
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE D. of C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 10 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2316 Tunlaw Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First L	Middle Moose	4. DATE OF DEATH January 21	Month 1959	Day 21	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1919	9. AGE (in years last birthday) 39 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Largehere		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO 111-11-1111		17. INFORMANT Barney T. V. Moose		Address 2316 TunLaw Road Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930		Marked cerebral edema				INTERVAL BETWEEN ONSET AND DEATH 24°	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		(b) intracerebral hemorrhage				24°	
(c) Disease of the rt. parato-occipital lobe						24 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		hence				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) hence					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from _____, 1957, to 1-21-1959, that I last saw the deceased alive on 1-21-1959, and that death occurred at 3A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1908 R St NW DC		DATE SIGNED 1-21-59			
ACTUAL SIGNATURE J. P. Murphy		PHYSICIAN'S NAME (Type) J. P. MURPHY					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 26, 1959	22c. NAME OF CEMETERY OR CREMATORIUM All Saints Cemetery	22d. LOCATION (City, town, or county) Fort Meyer Virginia	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Binchons		ADDRESS 3034 1/2 N Street NW	24a. REC'D. BY REGISTRAR Cathleen S. J. 1/2	24b. REGISTRAR'S SIGNATURE Cathleen S. J. 1/2			
			DATE JAN 23 '59				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00894

903

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Maryland		MARYLAND		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE District of Columbia		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 44 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 3712 Appleton Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First George	Middle Albert	Last MORLOCK	4. DATE OF DEATH	Month January	Day 23	Year 1959		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-93	9. AGE (in years last birthday) 65 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service	10b. KIND OF BUSINESS OR INDUSTRY U.S. State Dept.	11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Peter A. Morlock	14. MOTHER'S MAIDEN NAME Emily Root								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. None	17. INFORMANT (W) Mrs. Ethel B. Morlock, same as #2 above	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 420.1		<i>Myocardial infarction</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH .5 wks							
(b) DUE TO Generalized arteriosclerosis									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) U. S. Naval Hospital, NNMC	(County) 1-23-59	(State) Va.				
21. I certify that I attended the deceased from December 10, 1959 , to January 23, 1959 , that I last saw the deceased alive on January 22, 1959 , and that death occurred at 2:20A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC	DATE SIGNED 1-23-59
ACTUAL SIGNATURE <i>R. G. Muth</i>	M.D.								
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-27-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Va.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey Funeral Home, Bethesda, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE <i>R. G. Muth</i>					



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8
904

CERTIFICATE OF DEATH

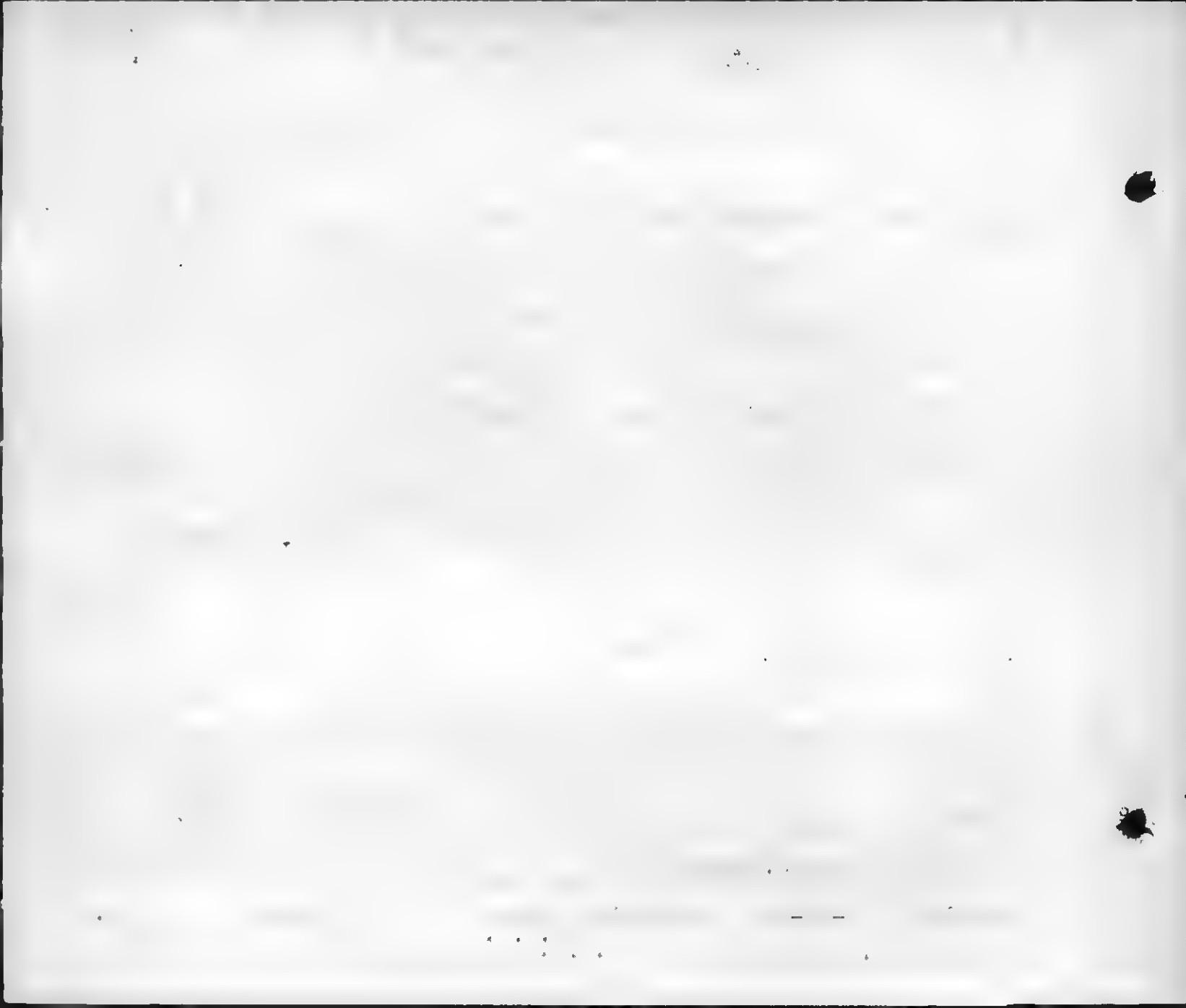
00895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 3 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11924 ANDREW COURT		d. STREET ADDRESS 11924 ANDREW COURT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES E. MURPHY	First	Middle	Last
4. DATE OF DEATH	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-89
9. AGE (In years lost/birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE SERVICE	11. BIRTHPLACE (State or foreign country) WASH. D. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM MURPHY	14. MOTHER'S MAIDEN NAME KATHRYN SOURBIER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 579-42-1912	17. INFORMANT DOROTHY M. GILLER	Address SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion Arteriosclerotic Heart Disease 8 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/10/1957 to 1/21/1959, that I last saw the deceased alive on 1/21/1959, and that death occurred at 9 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE John J. Curry M.D. ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spring, Md. DATE SIGNED 1/21/59			
PHYSICIAN'S NAME (Type) John J. Curry			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-59	22c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens	22d. LOCATION (City, town, or county) Arlington (State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. 3821 14th N.W.		24a. REC'D. BY REGISTRAR JAN 23 1959	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

UC895

905

CERTIFICATE OF DEATH

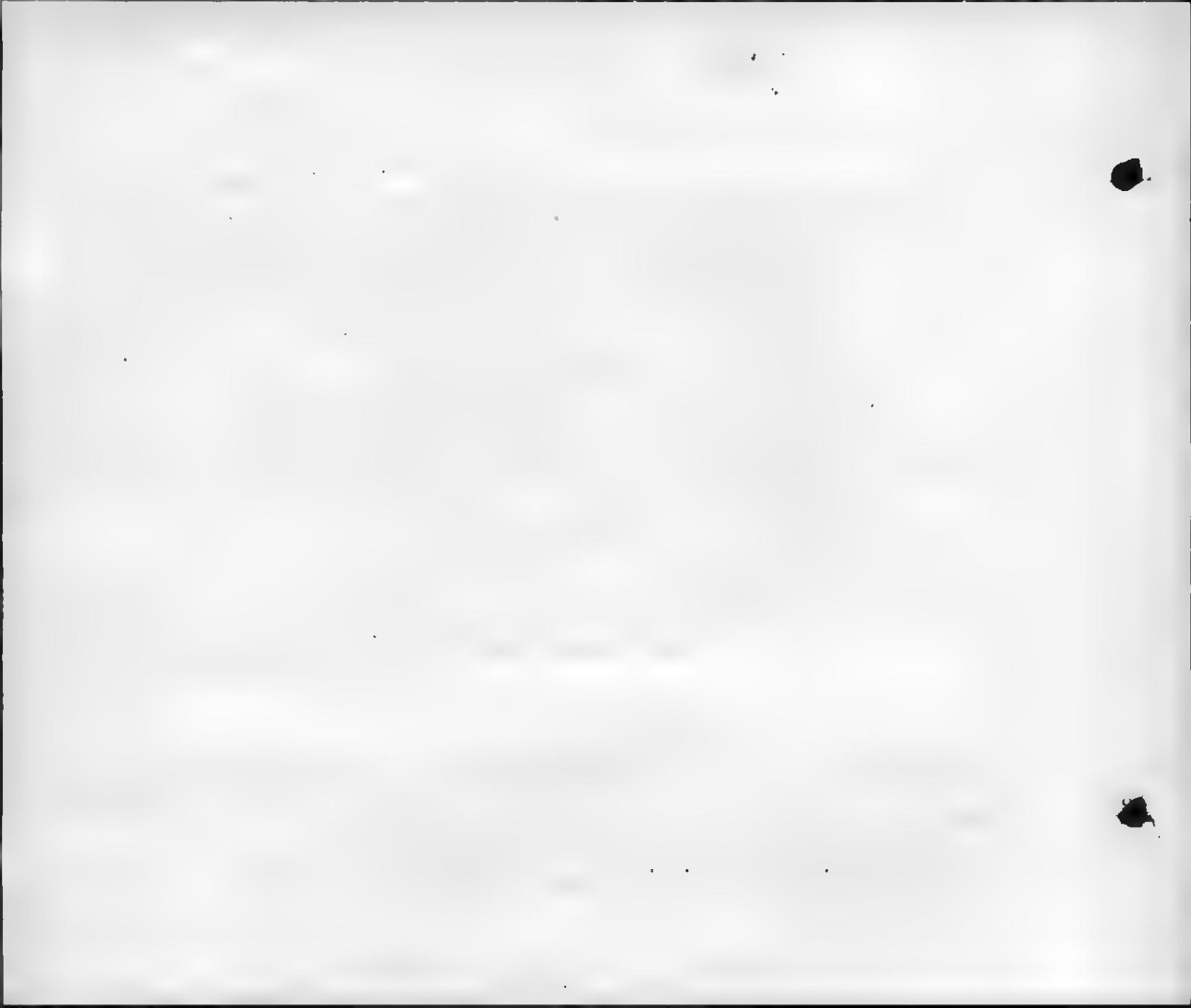
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District of Columbia		b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		d. STREET ADDRESS 3734 Foote Street, N. E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Fred	Middle Henry	Last Nevils	4. DATE OF DEATH January 24, 1959	Month January	Day 24	Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1896	9. AGE (In years lost birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Joseph Nevils		14. MOTHER'S MAIDEN NAME Hattie Thompkins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 124-07-1164		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac hypertrophy, Ascites, Chronic serositis, - peritonem								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center		20f. (City or town) Bethesda		(County) Montgomery	(State) Maryland
21. I certify that I attended the deceased from January 7, 1959, to January 24, 1959, that I last saw the deceased alive on January 24, 1959, and that death occurred at 10:25 A.M., from the causes and on the date stated above ACTUAL SIGNATURE <i>Guy O. Barnett</i>						ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1-24-59	
PHYSICIAN'S NAME (Type) Guy O. Barnett, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 30 1959		22b. DATE THEREOF Jan 30 1959		22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Cemetery		22d. LOCATION (City, town, or county) Shirlington		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frances Funeral Home		ADDRESS 389 R. St. NW		24a. REC'D BY REGISTRAR Date JAN 28 '59		24b. REGISTRAR'S SIGNATURE C. J. Kaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

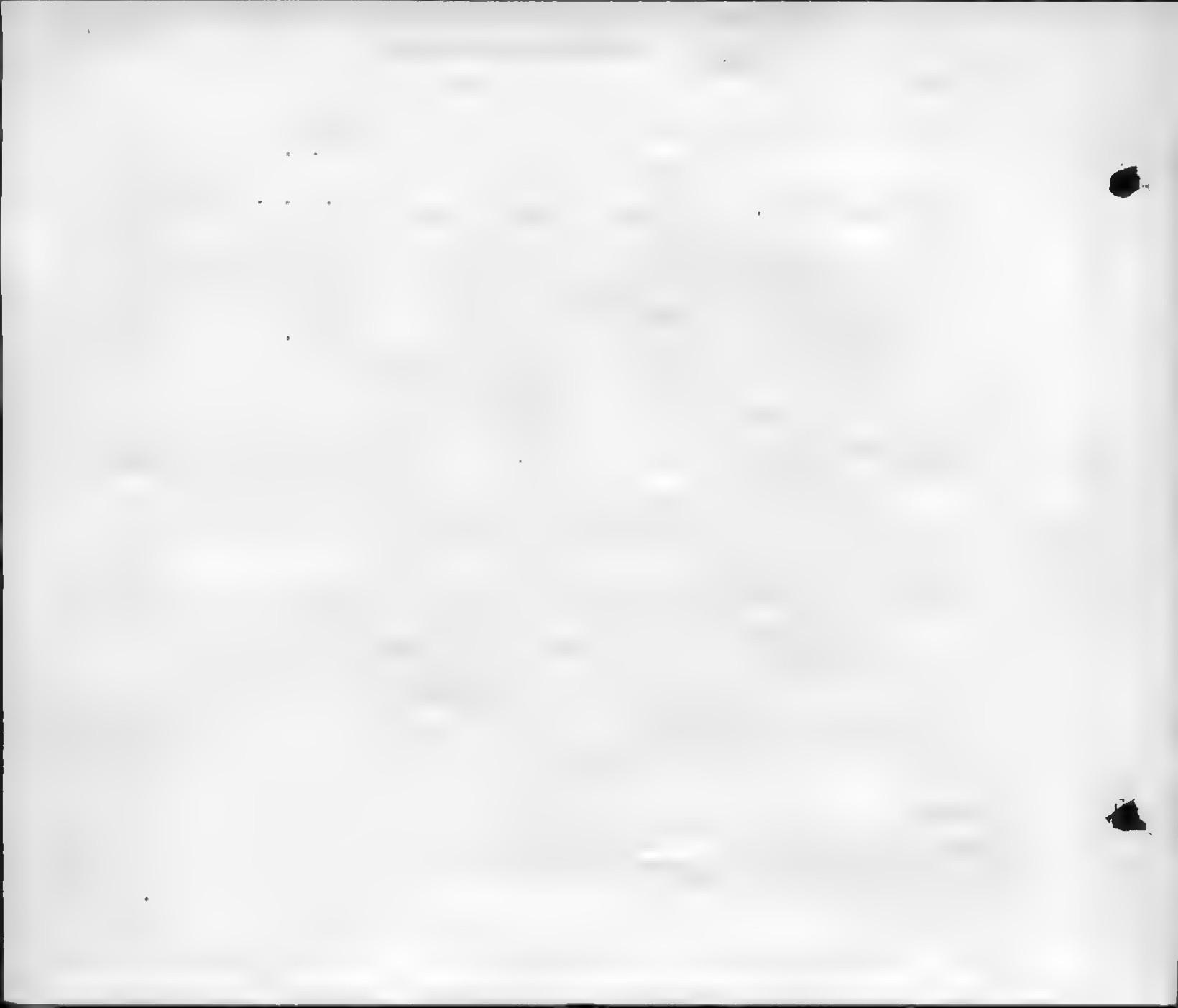
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906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 7530 12th St. N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8504 Rayburn Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First INNE	Middle North	Lost	4. DATE OF DEATH Jan 14 1959	Month Jan	Day 14	Year 1959
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/23/78	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Martinsville, Va.		
13. FATHER'S NAME John Harden Pedigo				14. MOTHER'S MAIDEN NAME Eleanor Davison				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no or unknown] If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Eleanor Campbell same as #1		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)				Abdominal Carcinomatosis Adeno carcinoma of Stomach INTERVAL BETWEEN ONSET AND DEATH yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Oct 14, 1958 to Jan 14, 1959				
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Martinsville	(County)	(State)
21. I certify that I attended the deceased from Oct 14, 1958 to Jan 14, 1959, that I last saw the deceased alive on Jan 14, 1959, and that death occurred at 10:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL E. Herbert Bauersfeld M.D. 1912 R St NW PHYSICIAN'S NAME (Type) E. Herbert Bauersfeld Washington D.C. DATE SIGNED 1/14/59								
22a. BURIAL/CREMATION REMOVAL (Specify) DEMOVAL		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Martinsville, Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Hause Co		ADDRESS 281-14th St. N.W. DC		24a. REC'D BY REGISTRAR Jan 16 1959		24b. REGISTRAR'S SIGNATURE C. H. Hause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

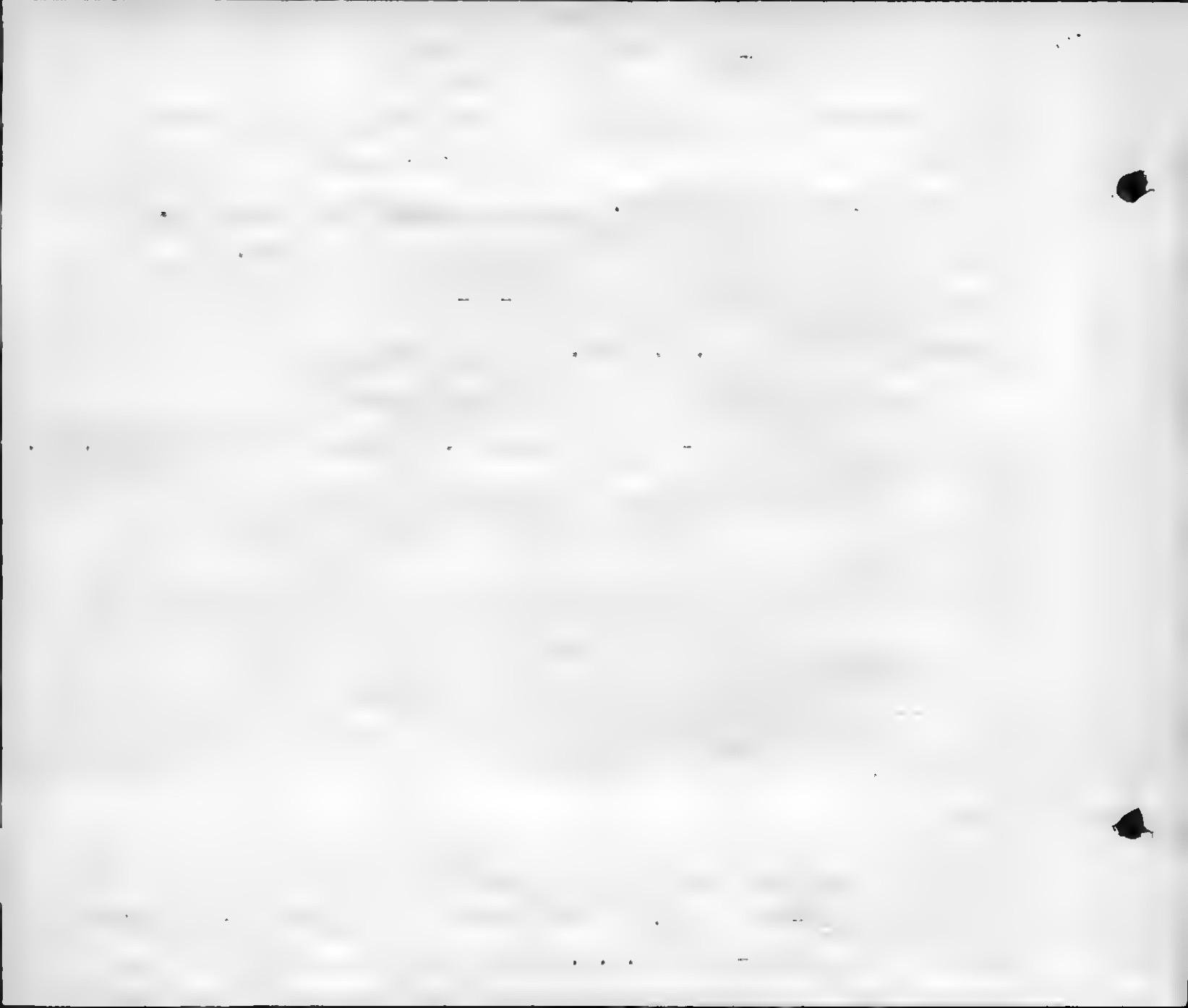
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907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium, 3008 McComas Ave.				d. STREET ADDRESS #3 Valley Park Valley Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Daniel	Middle	Last O'Connell	4. DATE OF DEATH Jan. 21	Month Jan	Day 21	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-78	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel O'Connell				14. MOTHER'S MAIDEN NAME Bridget Fealy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, No, or unknown] No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Joseph D. O'Connell		#3 Park Valley Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Insufficiency (Anemia)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Generalized arterosclerosis</i> DUE TO DUE TO (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>None</i>	(County) <i>1948</i>	(State) <i>January, 1959</i>	
21. I certify that I attended the deceased from <i>None</i> , 1948, to <i>January, 1959</i> , that I last saw the deceased alive on <i>Jan 20</i> , 1959, and that death occurred at <i>110A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Bernard A. Fitzgerald</i>	ADDRESS (Street, city or town, state) <i>217 University Blvd E</i>		DATE SIGNED <i>1-21-59</i>				
PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>	22. BURIAL, CREMATION, REMOVAL (Specify) Burial 1-24-59						
22b. DATE THEREOF 1-24-59	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) Bladensburg, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>	ADDRESS <i>3821-14th St. N.W. WashDC</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be given as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 237

CG893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

17 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2713 Colston Rd.

3. NAME OF
DECEASED
(Type or print)

First Middle Charles Joseph Parrott

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

5-15-08

9. AGE (In years
(in months if today))

50 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

Cable oplic R.E.P.Co.

12. STREET ADDRESS

2713 Colston Rd

13. IS RESIDENCE
ON A FARM
YES NO

14. DATE
OF
DEATH

1 - 3 - 1959

Month Day Year

13. FATHER'S NAME

George Parrott

14. MOTHER'S MAIDEN NAME

Susan Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown]

16. SOCIAL SECURITY NO.

17. INFORMANT

577-09-605 Eugene Parrott (wife)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

353.3

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Asphyxia

Laryngeal Obstruction

Bleeding into tongue

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

Sudden

Sudden

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

(d) Epilepsy

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Frank J. Blaschke

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. Blaschke

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

1-3-59

220. BURIAL, CREMATION, REMOVAL (Specify)

Burial

221. DATE THEREOF

Jan 7, 1959

222. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

223. LOCATION (City, town, or county)

Silver Spring Md

(State)

224. FUNERAL DIRECTOR'S SIGNATURE

#390

ADDRESS

475-HS, NW

246 REC'D BY REGISTRAR

DATE 1-3-59

246 REGISTRAR'S SIGNATURE

W. Blaschke



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00980

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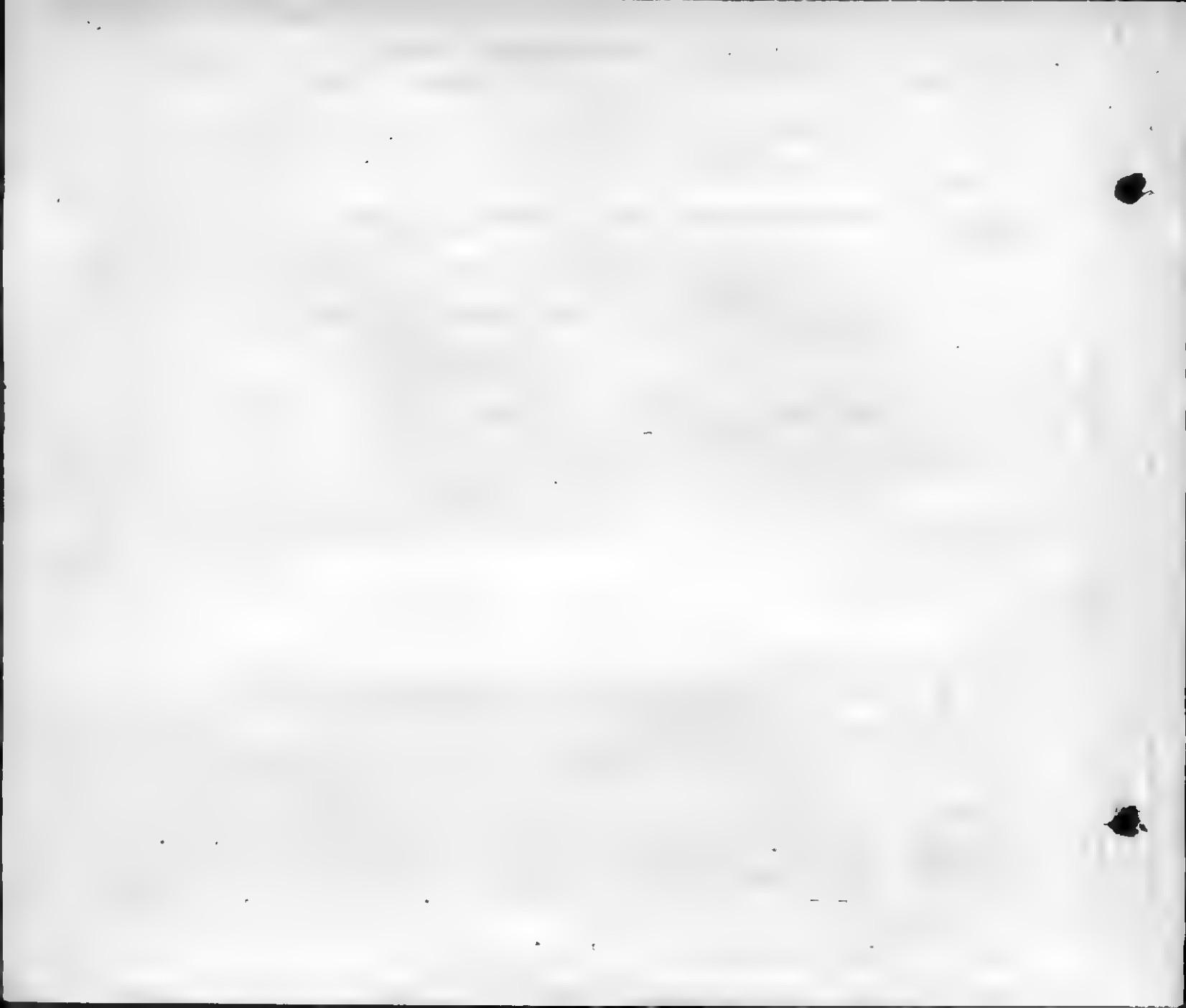
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	d. COUNTY <i>Maryland</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>	e. STREET ADDRESS <i>4720 South Chelsea Lane</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William H. Tattison</i>	First <i>William</i>	Middle <i>H.</i>	Last <i>Tattison</i>
4. DATE OF DEATH <i>1/31 1959</i>	Month <i>1</i>	Day <i>31</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3, 1896</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR <i>8</i>	11. IF UNDER 24 HRS. <i>28</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mercant Lawyer - Self Employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>	
10c. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Allen S. Tattison</i>		14. MOTHER'S MAIDEN NAME <i>Eva L. Hoffmann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-38-1408</i>	
17. INFORMANT <i>Son - William Tattison Jr.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.8</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>RESECTION CA OF COLON</i>	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 DAYS</i> <i>16 DAYS</i> <i>2 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>MULTIPLE POLYPS COLON</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 5009 Del Ray, Bethesda</i>		20f. (City or town) (County) (State) <i>5009 Del Ray, Bethesda, Md.</i>	
21. I certify that I attended the deceased from <i>December 1958 to Jan 31 1959</i> , that I last saw the deceased alive on <i>Jan 31 1959</i> , and that death occurred at <i>8:40 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert G. Angle</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-4-59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat'l Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Bethesda, Md.</i>	
		24b. REGISTRAR'S SIGNATURE DATE <i>FEB 4 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

910

CERTIFICATE OF DEATH

Reg. Dist. No.

00901

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c. LENGTH OF STAY IN 1b 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11018 Montrose Avenue		d. STREET ADDRESS 1108 Montrose Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First JOHN	Middle FRED	Last PETERSON	4. DATE OF DEATH Jan. 7,	Month Jan. Day 7 , Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 6, 1881	9. AGE (In years (last birthday) yrs.) 77	IF UNDER 1 YEAR Months 8 Days 1 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer -Retired Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis Peterson			14. MOTHER'S MAIDEN NAME Charlotte ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Jennie A. Peterson - Item #2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5272 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Hour a. m. p. m.	Month Jan. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parklawn	20f. (City or town) Rockville	(County) Maryland (State)
21. I certify that I attended the deceased from 1-29 , 19 57 , to 1-7 , 19 57 , that I last saw the deceased alive on 1-7 , 19 57 , and that death occurred at 2:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) None					
ACTUAL SIGNATURE <i>Morris Perry</i>	DATE SIGNED 1/7/59				
PHYSICIAN'S NAME (Type) Dr. Morris Perry - 11602 Georgia Ave., Silver Spring, Md.					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/59	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn	22d. LOCATION (City, town, or county) Rockville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland	ADDRESS	24a. REC'D BY REGISTRAR JAN 12 1959		24b. REGISTRAR'S SIGNATURE Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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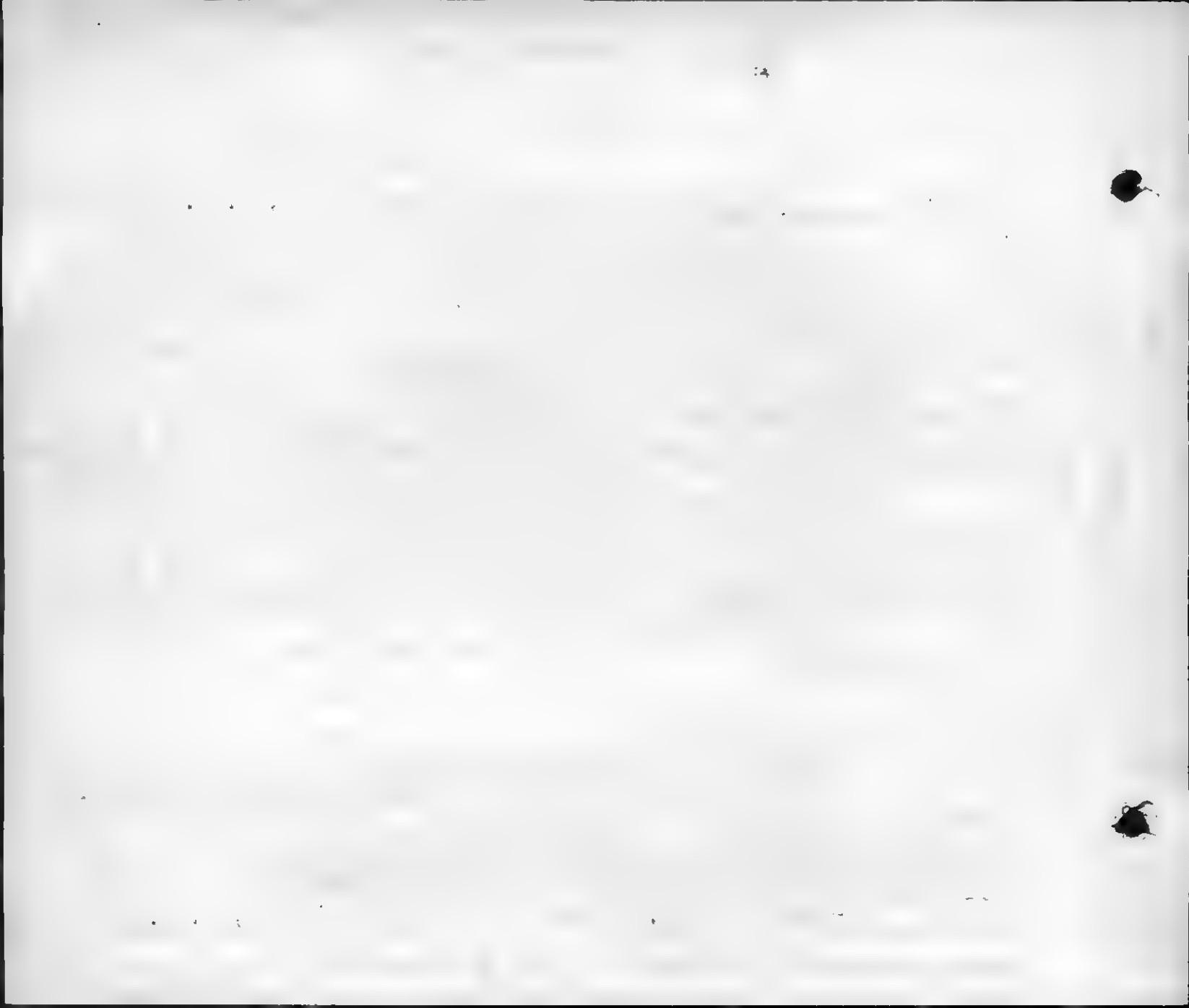
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eventide Nursing Home			d. STREET ADDRESS 1651 Newton Street, N. W.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First MARIE	Middle PINK	Last HJM	4. DATE OF DEATH 1 17 1959	Month Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (in years (last birthday) 88 7 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Nursing home records (no other available)	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 400.1 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH (a) 8 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. st. p. m.		Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE Bernard A. Fitzgerald			ADDRESS (Street, city or town, state) M.D. 217 University Blvd E. 1-17-59		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-20-1959	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Charles Son. 1756 Penna. Ave N.W.			ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 20 '59	24b. REGISTRAR'S SIGNATURE C. L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00903

778

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>9 1/2 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hosp.</i>		d. STREET ADDRESS <i>5 Lutes Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Albion</i>	Last <i>Piper</i>	4. DATE OF DEATH <i>JAN. 26 1959</i>	Month <i>JAN.</i>	Day <i>26</i>	Year <i>1959</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8-5-98</i>	9. AGE (In years last birthday) yrs. <i>60</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) <i>Attorney - Dept of Agric U. S. Gov't.</i>				11. BIRTHPLACE (State or foreign country) <i>Va.</i>			
13. FATHER'S NAME <i>Jesse F. Piper</i>				12. CITIZEN OF WHAT COUNTRY? <i>America</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. 17. INFORMANT <i>508-09-8547</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Synthesis of Liver</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>terminal circulatory failure</i>				8 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>at work</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>932 Elsworth</i>		(City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1939</i> , 19 <i>59</i> , to <i>Jan 26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1959</i> and that death occurred at <i>932 Elsworth</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i> M.D.							
ADDRESS (Street, city or town, state) <i>932 Elsworth, Silver Spring, MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/29/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. JOHN'S CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER B. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>JAN 26 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Raymond J. Ziska</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

911

CERTIFICATE OF DEATH

00904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 2703 Munson Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ira Lee Plummer		First	Middle	lost	4. DATE OF DEATH January 8 1959	Month	Day	Year
S SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH August 22, 1887	9 AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Louis Plummer		14. MOTHER'S MAIDEN NAME Minnie Loomis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 472-14-7799		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Perforation of Stomach Peptic Ulceration				INTERVAL BETWEEN ONSET AND DEATH 72 hrs.		
(c)						? 20 yrs		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hymphoma of bowel & liver & lung metastases						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center		20f. (City or town) Bethesda 14, Maryland	(County) National Institutes of Health	(State) Maryland
21. I certify that I attended the deceased from December 30 1958 , to January 8, 1959 , that I last saw the deceased alive on January 8, 1959 , and that death occurred at 5:30PM , from the causes and on the date stated above ACTUAL SIGNATURE Harold R. Silberman, M.D.						ADDRESS (Street, city or town, state) Bethesda 14, Maryland		
22a. BURIAL, CREMATION ON, REMOVAL (Specify) Cremation 1/12/59		22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem		22d. LOCATION (City, town, or county) Bethesda 14, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Chung Chao Funeral Home		ADDRESS 5103 Wisconsin Avenue N.W.		24a. REC'D BY REGISTRAR DALEN 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Koenig		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00779

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		811 MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>D. D. A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg (rural)</i>		d. STREET ADDRESS <i>R-1</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Montgomery Co. Gen Hosp P</i>				Last		DATE OF DEATH 1 - 12 1959		
3. NAME OF DECEASED (Type or print) <i>Sylvia</i>		First <i>J</i> Middle <i>Blumer</i>		Month		Day Year		
4. SEX <i>Female</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-14-58</i>	9. AGE (in years last birthday) 9 yrs	10. IF UNDER 1 YEAR Months <i>9</i> Days <i>28</i>	11. IF UNDER 24 HRS Hours Min. <i>12</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Blumer</i>		14. MOTHER'S MAIDEN NAME <i>Emma Neal</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Blumer (father)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BROCHOS-PNEUMONIA		
						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank J. Bloschert</i>		DATE SIGNED <i>1-12-59</i>						
EXAMINER'S NAME (Type) <i>FRANK J. BLOSCHELT</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/14/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Rose</i>		22d. LOCATION (City, town, or county) <i>Cloppers, Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Surden</i>		ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hansen</i>		
VS. ATSM SM 2 57								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00905

912

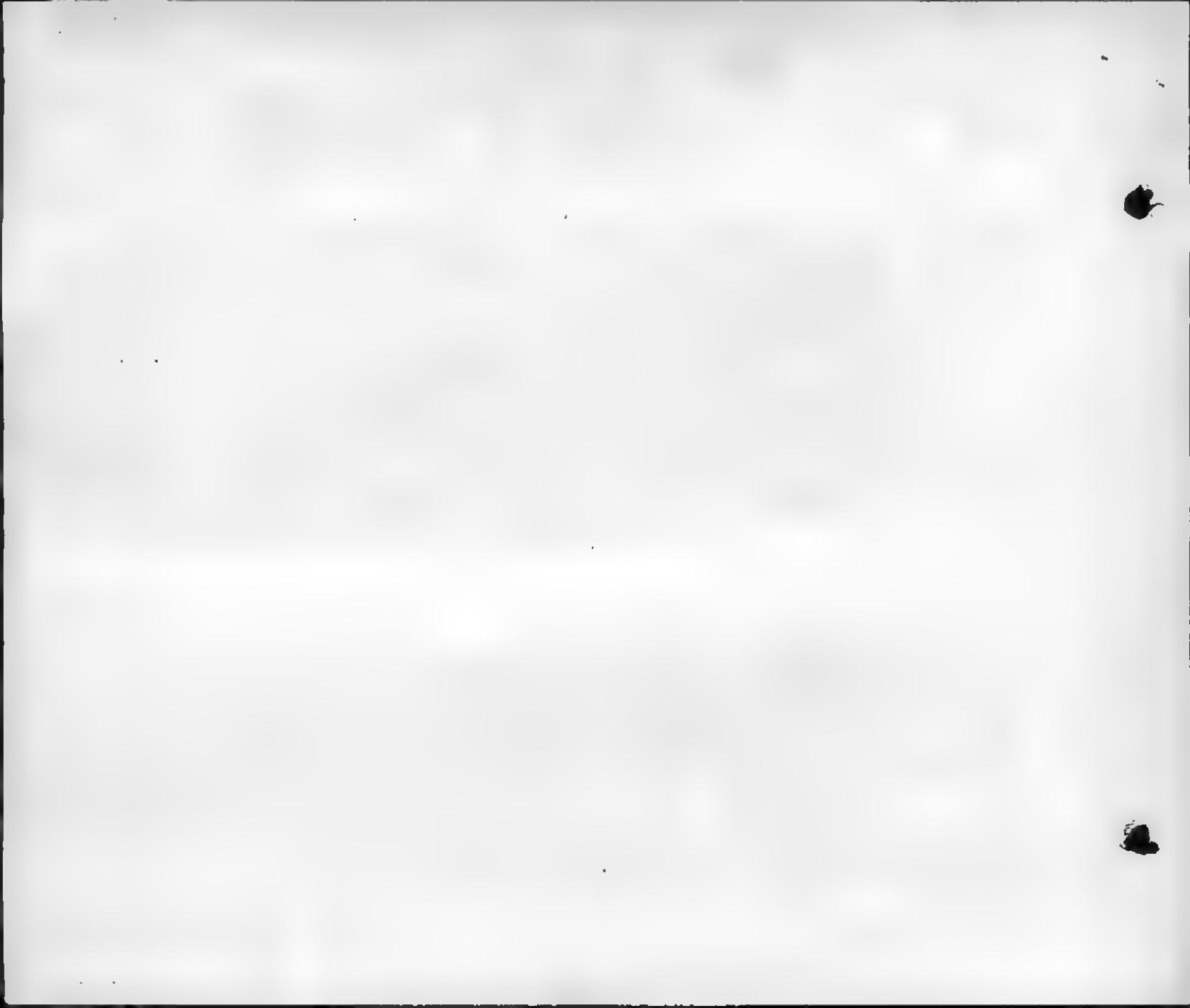
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE District of Columbia		COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 68 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 3,		d. STREET ADDRESS 1114 E Street, SE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle (None)	Last Potter	4. DATE OF DEATH	Month January	Day 25	Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8 February 1887	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY U. S. A.	14. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleaning Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) Missouri					
13. FATHER'S NAME Stephen Seasm Potter		14. MOTHER'S MAIDEN NAME Mattie Gilbert							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or date of service) No 577-50-8222		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Lobular Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO } Chronic Bronchitis + Chronic Pulmonary Fibrosis { (c) DUE TO						1 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hodgkin's Disease								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 18, 19 58, to January 25, 19 59, that I last saw the deceased alive on January 25, 19 59, and that death occurred at 10:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Nathan S. Taylor M.D. ADDRESS (Street, city or town, state) The Clinical Center PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D. DATE SIGNED 1-25-59									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-59		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Lincoln Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Dr. J. Chamberlain & Son		ADDRESS 517-11th St. N.E.		24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE J. S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be signed by the hospital or attending physician.

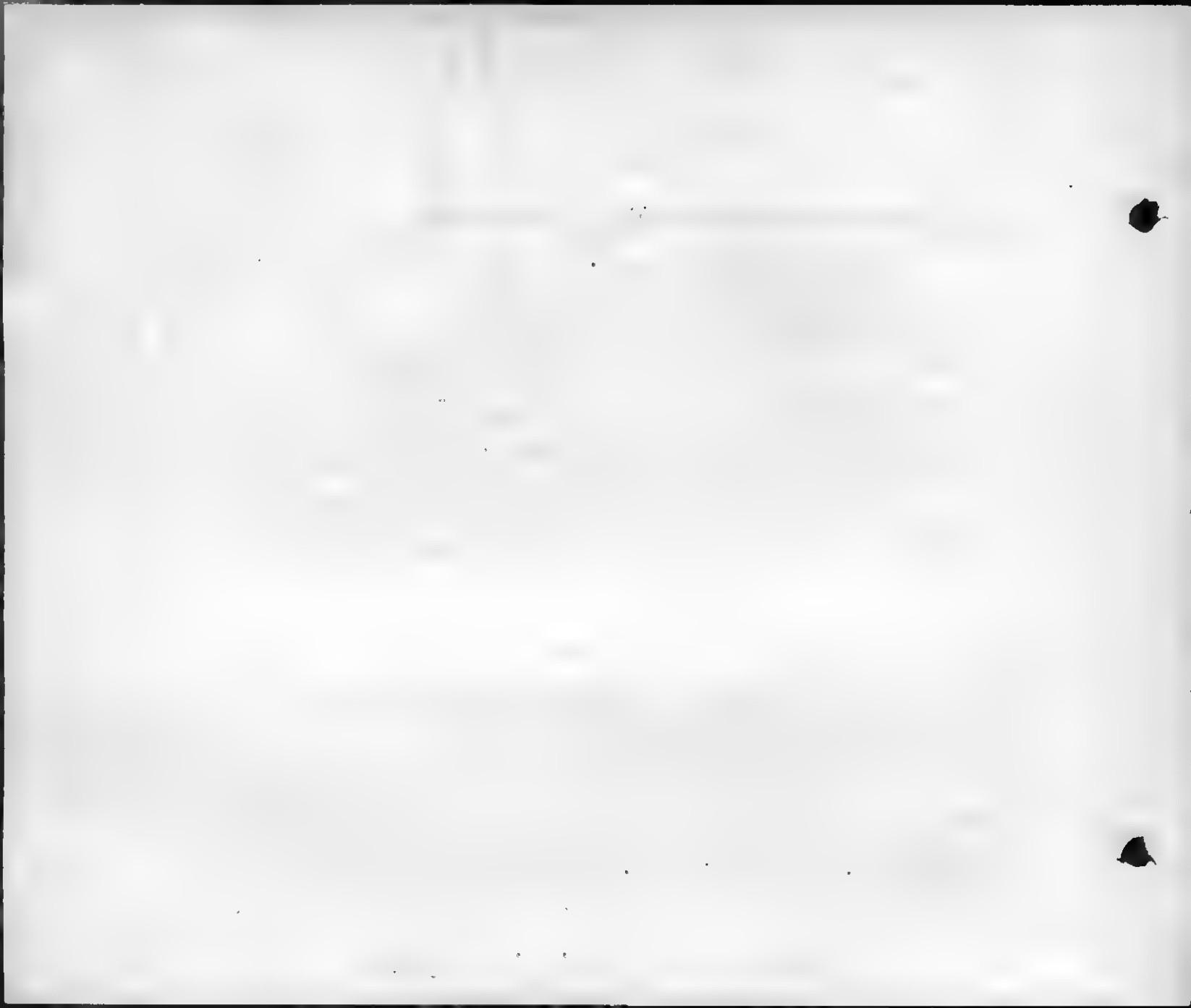
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

913 CERTIFICATE OF DEATH

Reg. Dist. No. **00906**

1. PLACE OF DEATH o COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE MARYLAND	
b. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 52 DAYS	
d. NAME OF HOSPITAL (If not in hospit., give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) ROBERT		First I.	Middle POWELL
4. DATE OF DEATH JANUARY 7 1959		Month	Day Year
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/92
9. AGE (in years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME WILLIAM POWELL		14. MOTHER'S MAIDEN NAME IDA --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary insufficiency INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema of lungs. (c) Hypertensive Cardio Vascular disease 10%			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6, 1957 , to Jan 6, 1957 , that I last saw the deceased alive on Jan 6, 1957 , and that death occurred at 4:35A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND			
ACTUAL SIGNATURE A. D. Bonifant, M.D. DATE SIGNED January 6, 1957			
PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D. SANDY SPRING, MARYLAND			
22a. BURIAL CREMATION, REMOVED 1/10/59		22b. DATE THEREOF 1/10/59	
22c. NAME OF CEMETERY OR CREMATORIUM Bush Park,		22d. LOCATION (City, town, or county) (State) Cooksville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sundeen		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE JAN 11 1959		24b. REGISTRAR'S SIGNATURE Bob Sundeen	



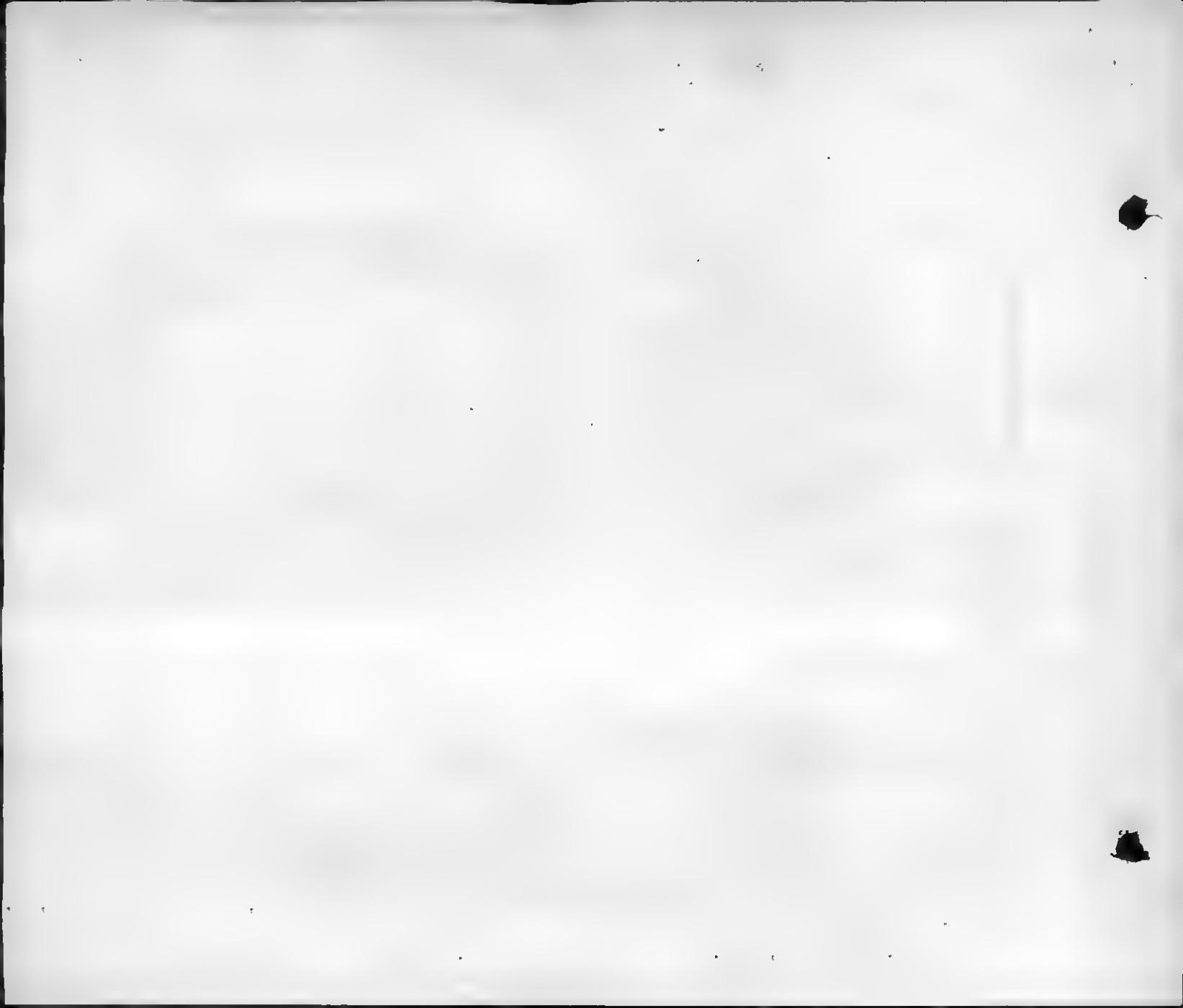
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00907

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL DIRECTOR: This certificate shall be executed within 24 hours after death. If any delay occurs, please execute it in pencil, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. _____											
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)									
a. COUNTY		b. STATE									
Montgomery		Md									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Silver Spring		56 Silver Spring									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS									
525 Bonifant Rd - R-1		525 Bonifant Rd - R-1									
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH									
First MIDDLE		Month Day Year									
Kate OLIVIA Pries		Jan 6 1959									
5. SEX		6. COLOR OR RACE									
f. w		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH									
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 3/18/1868									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY									
housewife		own home									
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Pa		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
John W. Norban		Mary Miller									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO.									
(If yes, give war or dates of service)		none									
17. INFORMANT		Address									
Harold Pries (son)		Ivan 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		3 hrs.									
434.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED									
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type)		1-6-59									
22b. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 1/11/59		22c. NAME OF CEMETERY OR CREMATORIAL Methodist Church Cemetery									
22d. LOCATION (City, town, or county) Conestoga, Lancaster County, Pa. (State)											
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY INC.		24a. REC'D BY REGISTRAR SILVER SPRING, MD.									
Raymond A. Ziska		24b. REGISTRAR'S SIGNATURE DATE JAN 9 '59									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00908

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
Montgomery		MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park		2 days		Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Washington Sanitorium & Hospital		3706 Flyers Mill Rd			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
E. Lida		Cecelia	Rarey	1 - 21 - 1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
F.	W		4-24-97	6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
hairdresser				D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Chas E. Kenya		Charlotte C. Hazel		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO		17. INFORMANT	
no		Unknown		Washington Sanitorium & Hospital Corp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		3 weeks			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b)		5 years			
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Massive Hemorrhage due to tubercular disease of the lungs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.		DATE SIGNED			
ACTUAL SIGNATURE		Robert A. Humphrey, M.D. 4/19/59			
PHYSICIAN'S NAME (Type)		Valencia Island, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		1-24-59		Holy Rood	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Robert A. Humphrey 7657 Wisconsin Blvd.				DATE 3 '59	
				24b. REGISTRAR'S SIGNATURE	
				C. A. & J. Inc.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00903

780

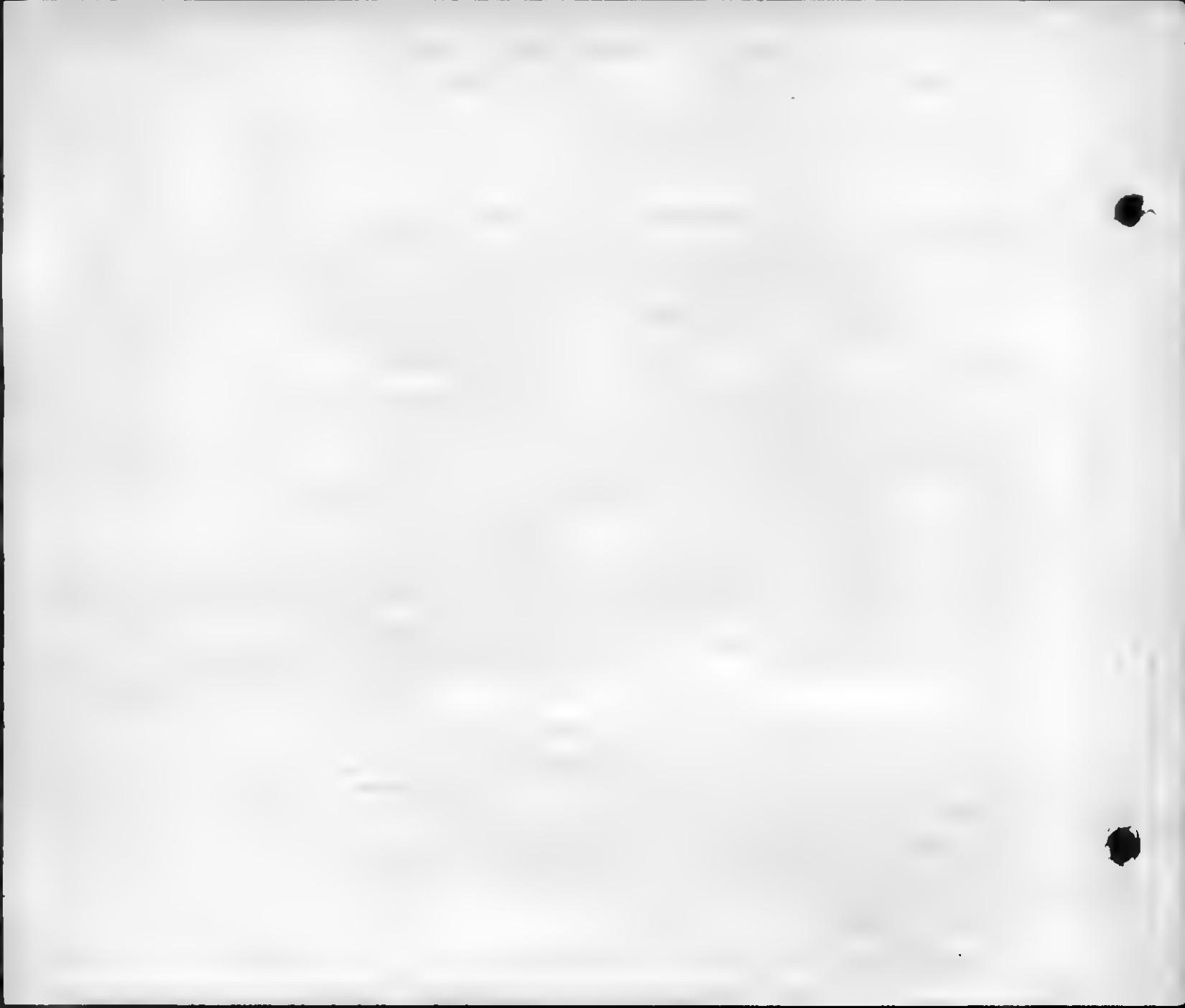
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Montgomery Maryland		Penns.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Takoma Park		10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Washington Sanitarium & Hosp.		2626 Milford Drive	
3. NAME OF DECEASED (Type or print)		First Delta	Middle Fae
4. DATE OF DEATH		Month 14	Day 1969
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		Cauc.	B. DATE OF BIRTH 2-7-83
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW.		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Nichol		14. MOTHER'S MAIDEN NAME Nancy Neff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ex. no. of rank/branch) No		16. SOCIAL SECURITY NO. 17. INFORMANT Niece - Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 11 days	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Circulatory disease	
(b)		DUE TO Cerebrovascular Failure, Berlin	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		M.D. Robert A. Flare, M.D. 1/4/69	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-59	
22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) St. Charlesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Dead Funeral Home		24a. REC'D BY REGISTRAR DATE JAN 21 '59	
ADDRESS 4817 Ga Ave, St. Louis		24b. REGISTRAR'S SIGNATURE John S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be countersigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00910

~~1~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

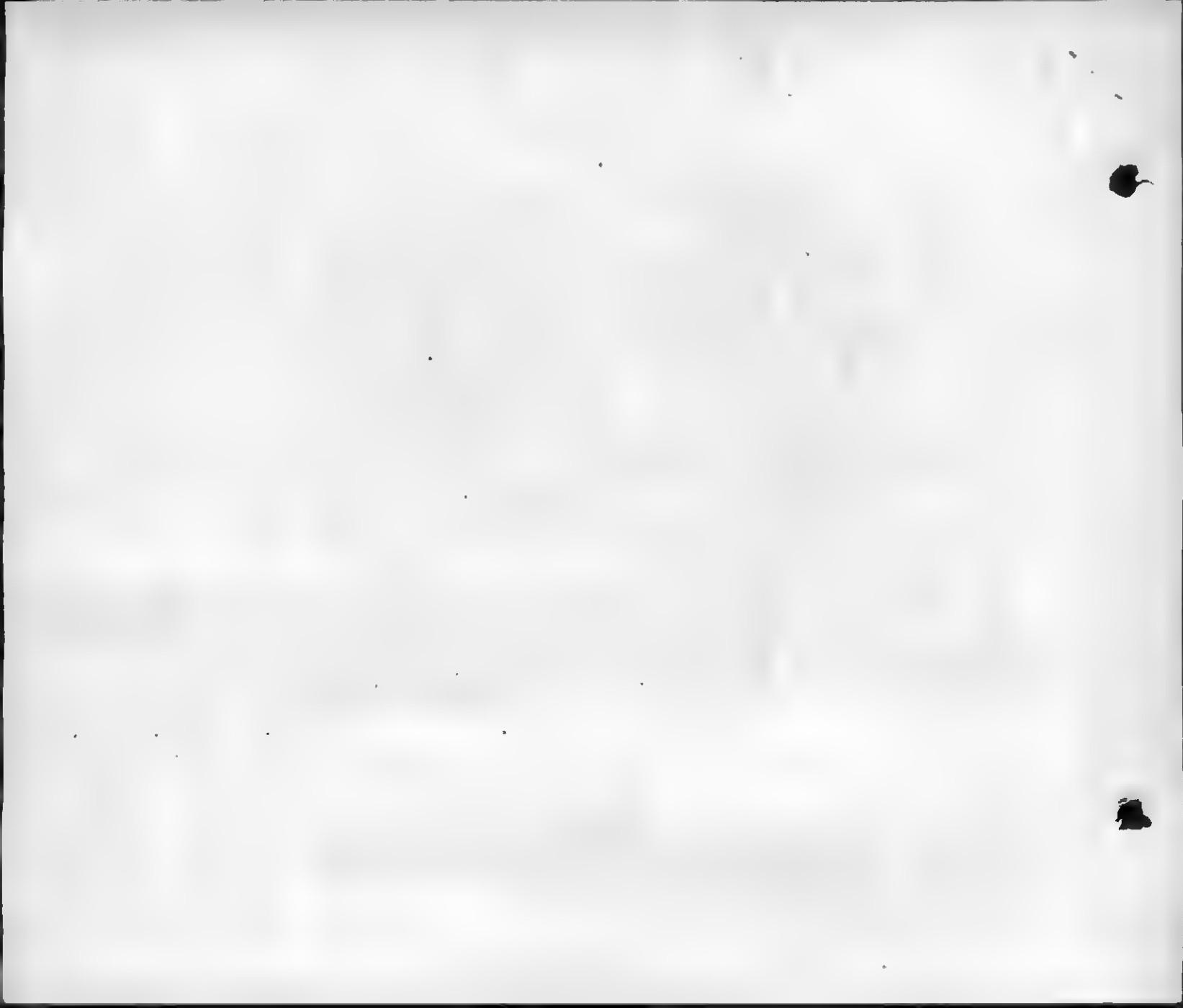
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		915 Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		d. STATE California		b. COUNTY	
Bethesda		4 mo.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
National Institute of Health				Los Angeles 27			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day
Earl Joseph Rasico				Jan. 29, 1959		1959	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years from birthday)	
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/29/1896		62 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Sales manager		Self employed		Ill.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
Francis X Rasico		Cora Stark					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
		Unknown		Hosp. Records		?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage (rt.)							
403.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
Aplastic anemia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
		No history. Probably fell in hosp. room					
20c. TIME OF INJURY Hour a. m. ? 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesd	
p. m.				hosp.		(County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE		<i>Frank J. Broschart</i>		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/29/59	
EXAMINER'S NAME (Type)		Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Los Angeles, California (State)	
Bur-Transit		1/30/59		Los Angeles			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey		Bethesda, Maryland		JAN 30 '59		L. M. d. Henry	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be given to the funeral director as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

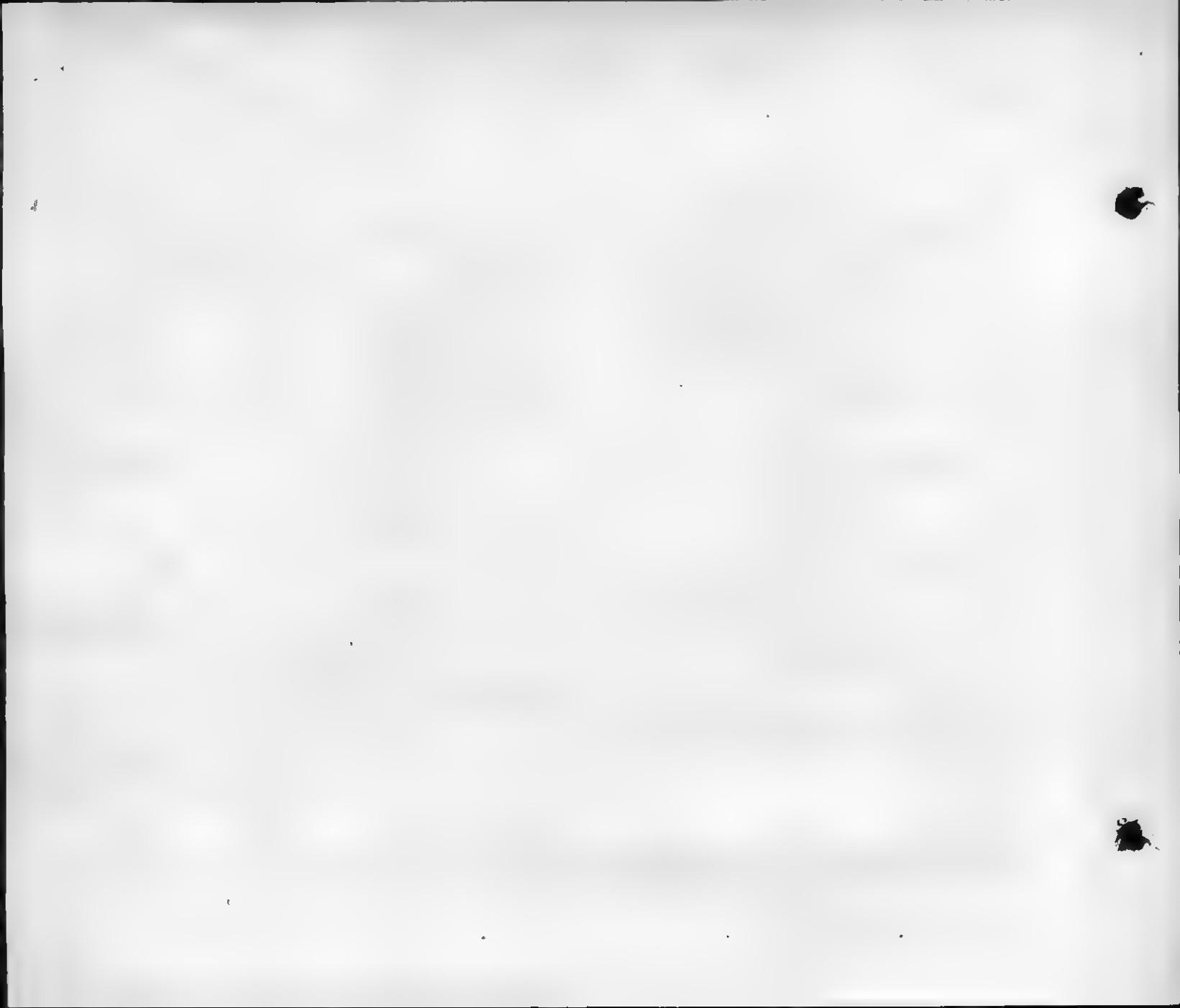
00911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery MARYLAND		o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park	8 hrs.	Silver Spring.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Washington Sanitarium Hospital	9700 Silverwood Lane		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Ruth		W	ARREN REDMILES
4. DATE OF DEATH	Month	Day	Year
	1	- 26 -	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-18-1898
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
60 yrs.	Months Days Hours	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
H.S.W.F.	Own home	D.C.	AMERICAN
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
JAMES Pumphrey	Lydia Reed		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO	17. INFORMANT	Address
	yes	Hospital Record.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	ca 48-15		
480.1	CORONARY Occlusion Acute		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO		
	(b) CORONARY ARTERIOSCLEROSIS		
	DUE TO		
	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from _____, 1959, to _____, 1959, that I last saw the deceased alive on _____, 1959, and that death occurred at _____, M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE <u>Bernard A Fitzgerald</u>	M.D. 217 University Street, 1-26-59		
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>	Physician's license # 123456789		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/29/59	22c. NAME OF CEMETERY OR CREMATORIUM TRINITY CEMETERY	22d. LOCATION (City, town, or county) UPPER MARLBORO, MARYLAND (State)
23. FUNERAL DIRECTOR'S SIGNATURE, INC. <u>WILLIAM E. PUMPHREY, INC.</u>	ADDRESS <u>Chambers & Associates</u>	24a. REC'D BY REGISTRAR DATE JAN 28 59	24b. REGISTRAR'S SIGNATURE <u>John O'Brien</u>

TO HOSPITAL may be referred to **TO FUNERAL** Director: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00912

916

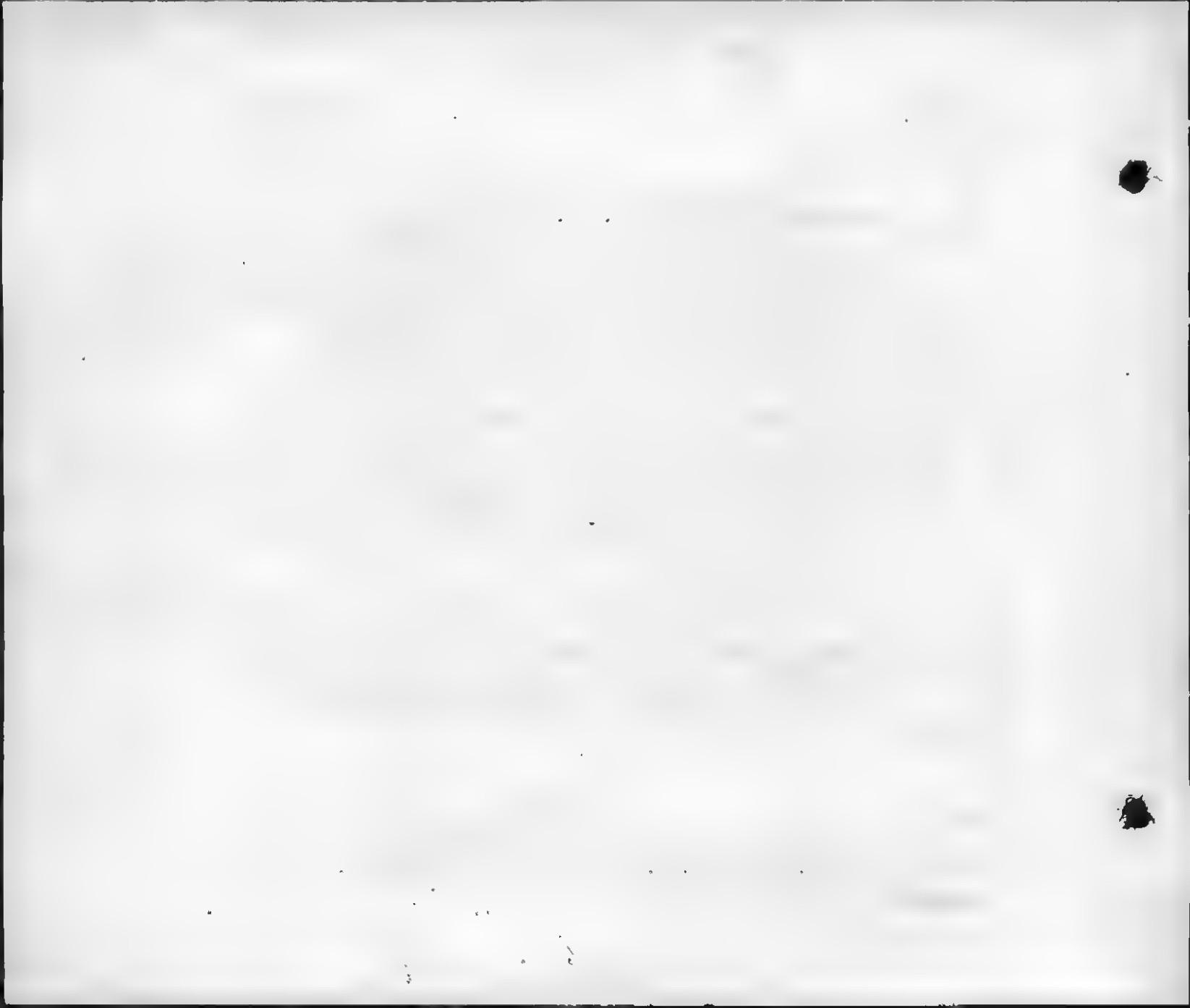
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Radford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 99 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route 1, Box 135		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Elaine	Last Reed	4. DATE OF DEATH	Month January	Day 6,	Year 1959
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1940	9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William I. Reed				14. MOTHER'S MAIDEN NAME Lucille Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 225-54-6845		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 105.4 DUE TO Massive Gastrointestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) DUE TO Thrombocytopenic Purpura Nephrotic Syndrome (c) Systemic Lupus Erythematosus							
INTERVAL BETWEEN ONSET AND DEATH 9 Hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) National Institutes of Health		(County) (State)	
21. I certify that I attended the deceased from September 29, 1958, to January 6, 1959, that I last saw the deceased alive on January 6, 1959, and that death occurred at 8:38 P.M., from the causes and on the date stated above							
ACTUAL SIGNATURE <i>Leon G. Smith</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Leon G. Smith, M. D.		DATE SIGNED 1-7-59					
22a. BURIAL, CREMATION, Specify		22b. DATE THEREOF 1/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Family Cemetery		22d. LOCATION (City, town, or county) Radford, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE <i>Curving L. Snowdon</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06913

917

CERTIFICATE OF DEATH

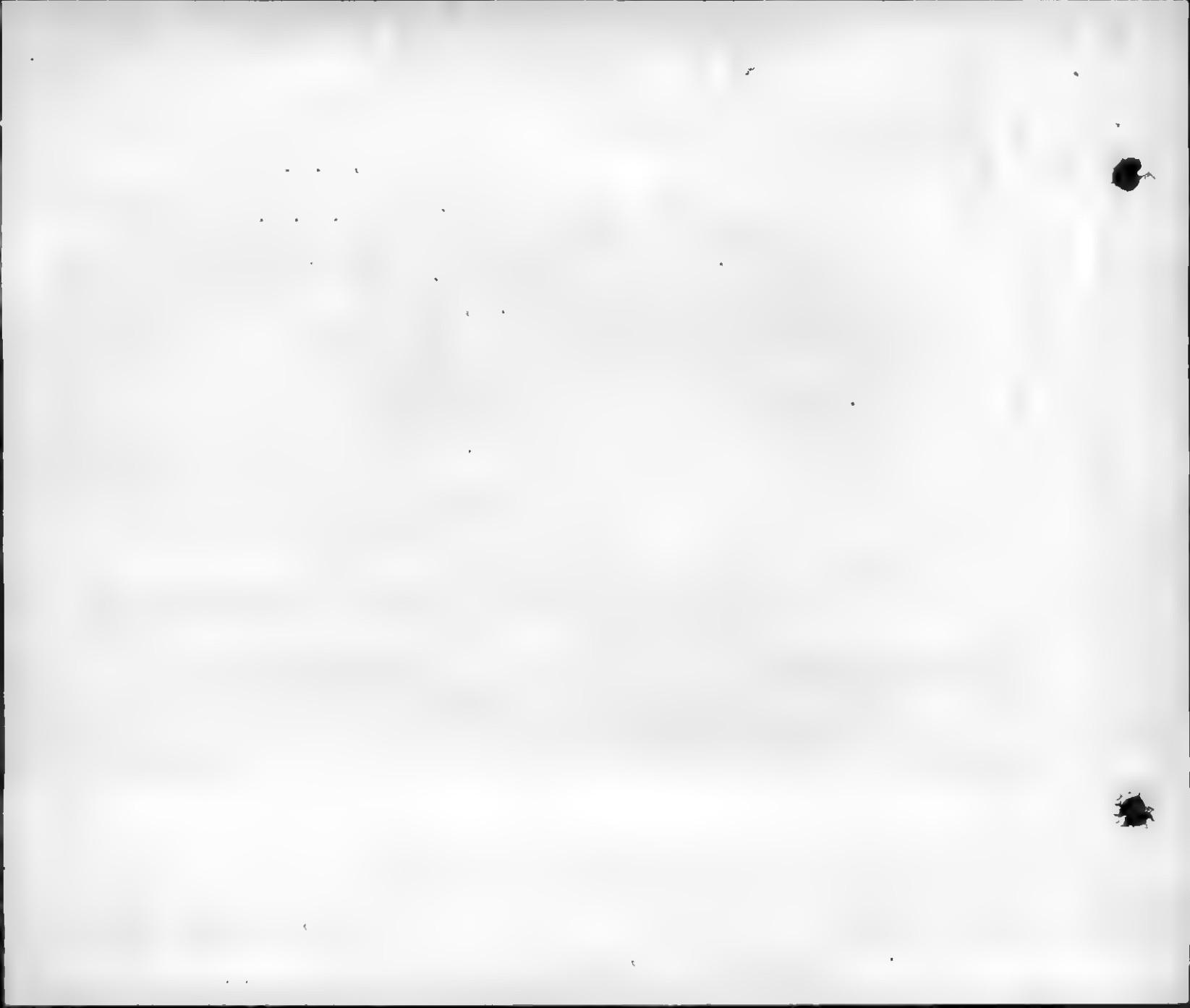
Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		a. STATE b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
3. NAME OF DECEASED (Type or print) STELLA L.		d. STREET ADDRESS 3249 "P" Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH January 24,		Month January		Day Year 19 59	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 4, 1875	9. AGE (in years last birthday) 83	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 20 Hours 0 Min
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Jasper H. Lawman		14. MOTHER'S MAIDEN NAME Leanore Ward		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Janice R. Marlow-Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Degeneration			
DUE TO 4420.0		INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis, Severe.			
(c)		5 years plus.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1958 to Jan. 24, 1959 that I last saw the deceased alive on Jan. 24, 1959 , and that death occurred at 10:59 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Thomas H. Hindman</i>		ADDRESS (Street, city or town, state) 3935 Baltimore St., DATE SIGNED 1/24/59			
PHYSICIAN'S NAME (Type) Thomas A. N. Hindman					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE John S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

796

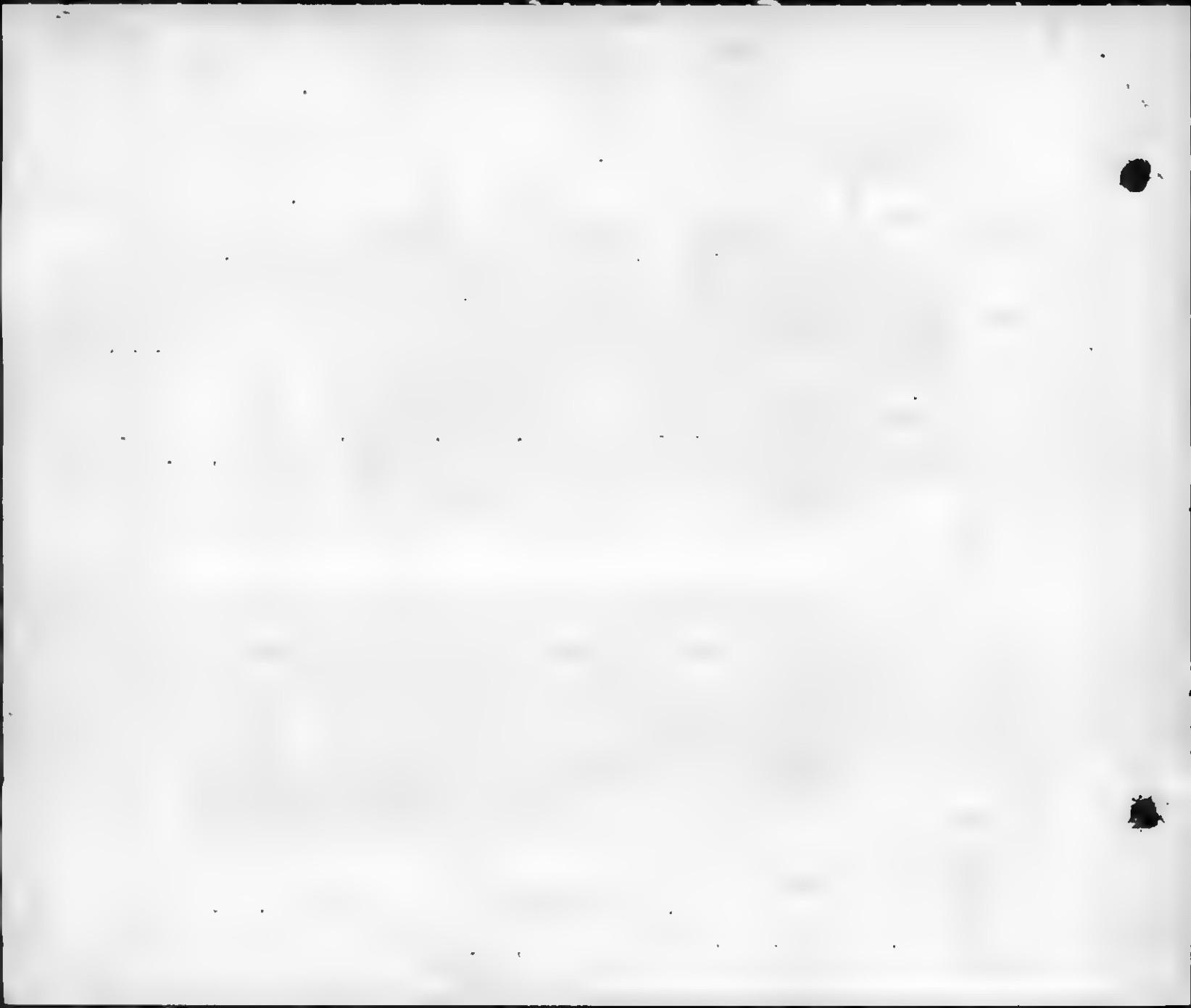
CERTIFICATE OF DEATH

Reg. Dist. No. 00914

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MA YLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 3½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4600 GREAT OAK ROAD		e. STREET ADDRESS 4600 GREAT OAK ROAD	
3. NAME OF DECEASED (Type or print) MINNIE LOUISE ROESCH		4. DATE OF DEATH JAN. 14 1959	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/73
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR, F. UNDER 24 HRS Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN M. ROLF		14. MOTHER'S MAIDEN NAME WAITSTILL COOK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 321-18-6852D	
17. INFORMANT Mrs. Joe A. Hinton, 4600 Great Oak Rd. Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14, 1956, to Jan 27, 1957, that I last saw the deceased alive on Jan 14, 1957, and that death occurred at 12:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>A. D. Bonjard</i> M.D. <i>Sandy Spring, Md.</i> 1/14/57			
PHYSICIAN'S NAME (Type) A. D. BONJARD			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/15/59	
22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL		22d. LOCATION (City, town, or county) PRINCE GEO. CO., MA YLAND	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. BONJARD, INC. <i>Alphonse L. Bonjard</i>		24a. REC'D BY REGISTRAR SILVER SPRING, MD. JAN 19 59	
		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00915

918

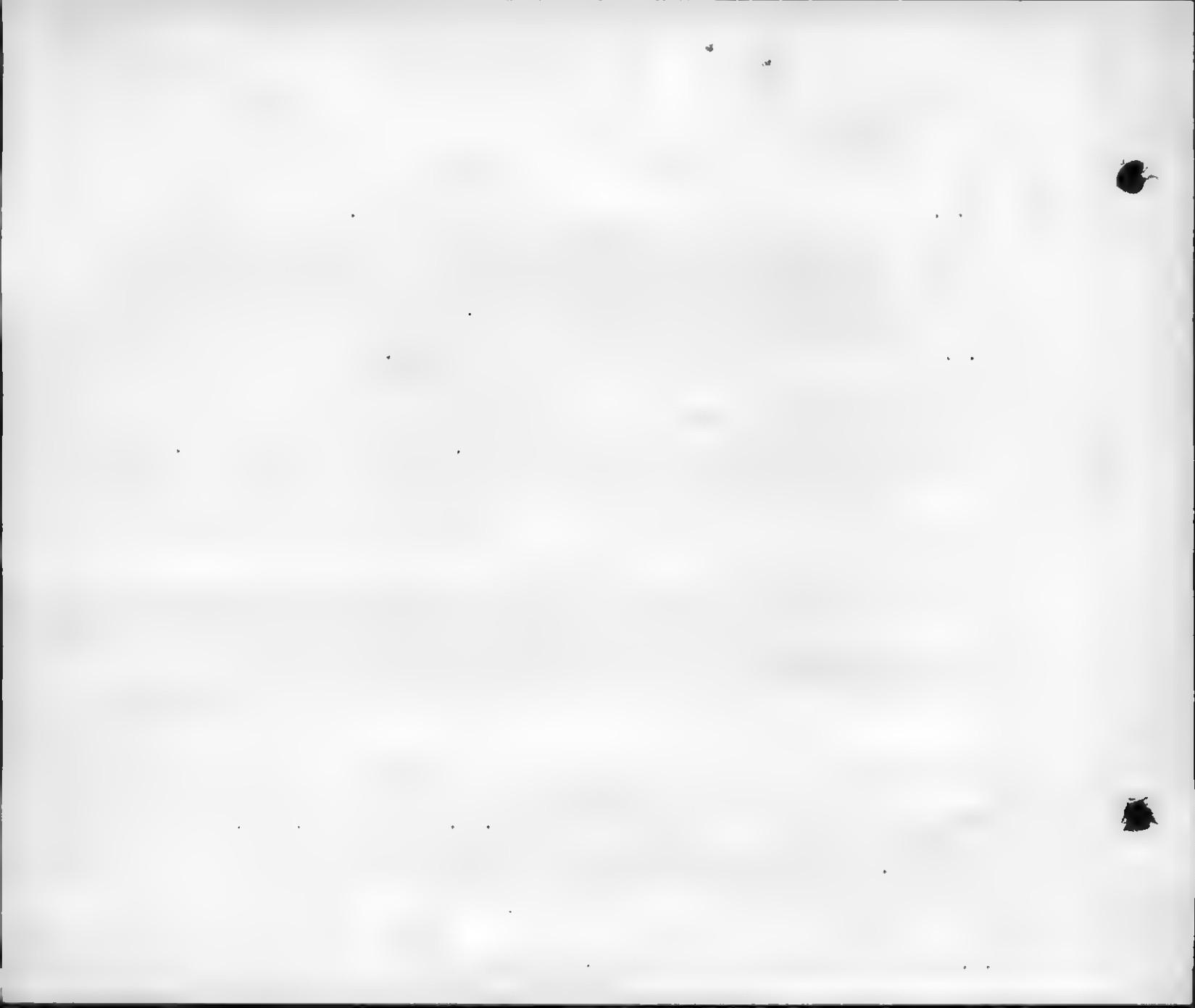
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be rejoined to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOULIS		d. STREET ADDRESS 40 CORNHILL ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNEST	First	Middle WALDO	Last ROGERS	4. DATE OF DEATH 1	Month 20	Day 1959	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 NOVEMBER 1902		9. AGE (In years less than birthday) 56 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRIS H. ROGERS				14. MOTHER'S MAIDEN NAME JESSIE HAMILTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW 11		17. INFORMANT DOROTHY H. ROGERS, 40 CORNHILL ST., ANNAPOLIS, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) RESPIRATORY ARREST BRONCHIOGENIC CARCINOMA RT LUNG 1 YEAR INTERVAL BETWEEN ONSET AND DEATH —							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 13, 1959 , to January 20, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 3:03A M , from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>F. S. Caldwell</i> DATE SIGNED 1-20-59 PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (See 22b) Burial-Shipment 1-21-59		22b. DATE THEREOF 1-21-59		22c. NAME OF CEMETERY OR CREMATORIUM Local Cemetery		22d. LOCATION (City, town, or county) (State) Webster Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Taylor</i> J. M. Taylor Funeral Home, Annapolis, Md.		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE AN 22 '59		24b. REGISTRAR'S SIGNATURE <i>L. S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00918

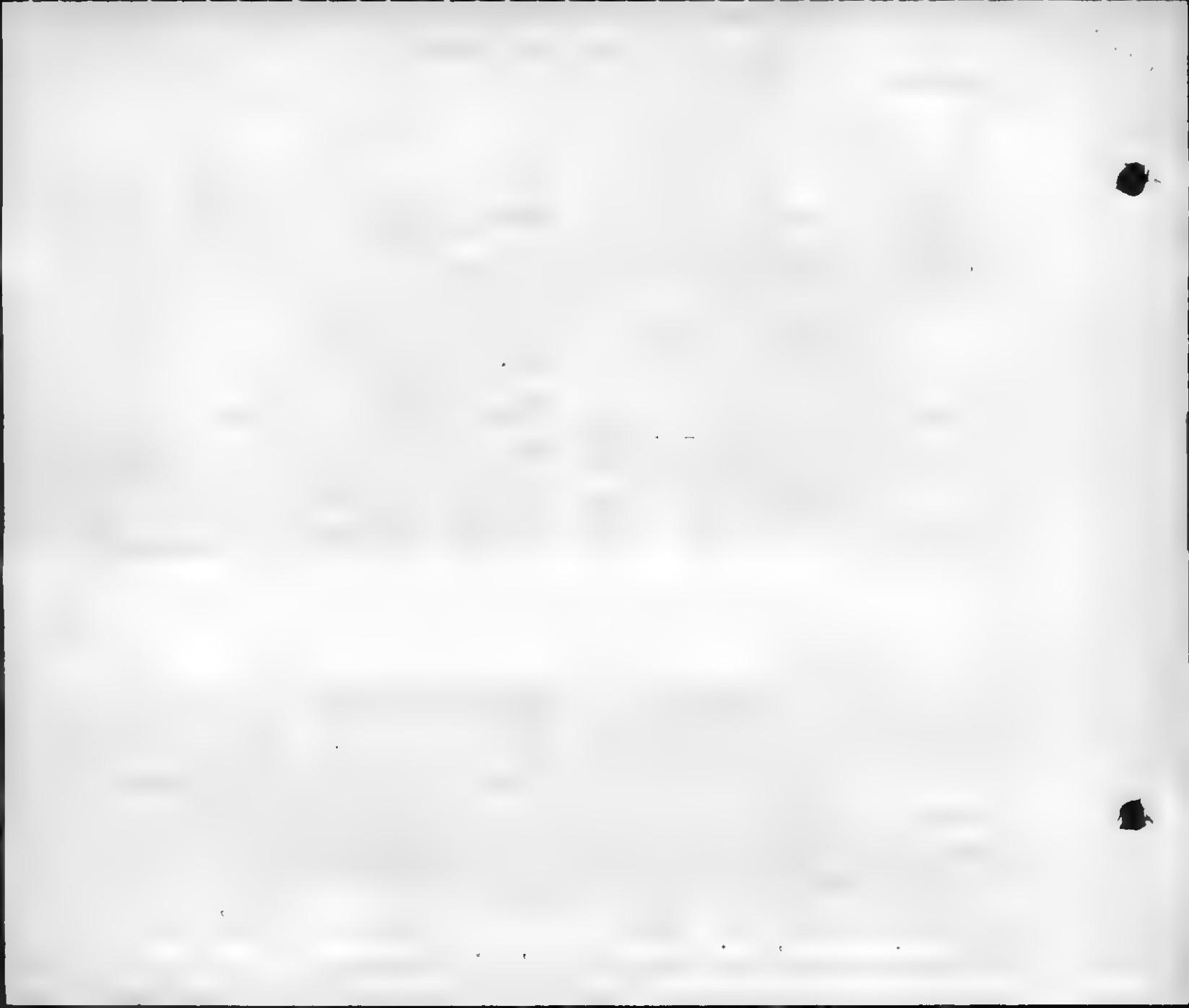
919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution give name before admission)					
Montgomery MARYLAND		a. STATE MD	b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Silver Spring	24 yrs	Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS						
8008 Piney Branch Road	8008 Piney Branch						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last				
Ralph Edward		Ruby					
4. DATE OF DEATH	Month	Day	Year				
	JAN	15	1959				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR 67 yrs	IF UNDER 24 HRS. Months Days Hours Min.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/27/91				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Sew. Manager		Kodak Photo Film Co.		Ohio			
13. FATHER'S NAME		14. MOTHER'S MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?			
RALPH EDWARD RUBY		EMMA BROWN		U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
yes		214-03-8968		Mrs K Ruby 8008 Piney Branch Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days					
Acute Pneumonia Viral							
4x		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)	Acute Coronary Accension				
{		DUE TO	immediate				
(c)			Ch. Deg Myocarditis-Hrd Decamp				
			24 days				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Very short breath due to a - Dead in Coughing Spell							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
19							
21. I certify that I attended the deceased from 1/19/1959 to 1/15/1959, that I last saw the deceased alive on 1/14/1959, and that death occurred at 8:20 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED Howard T. Morse M.D. 7030 Carroll Ave 1/15/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/59		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. FUMFREY, INC.		ADDRESS SILVER SPRING, MD.		24a REC'D BY REGISTRAR DATE JAN 19 59		24b. REGISTRAR'S SIGNATURE Howard E. Fumfrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00917

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY		920		Reg. Dist. No.	
Montgomery		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
Olney		D.O.A.		Mt. Zion	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Derwood		RFD	
Montgomery Co. Gen.		Lost		DATE OF DEATH	
3. NAME OF DECEASED (Type or print)		First		Month	
George Daniel Russell		Middle		Day	
5. SEX		6. COLOR OR RACE		Year	
male		col		9. AGE (in years less birthday)	
7. MARRIED		NEVER MARRIED		59 yrs.	
<input checked="" type="checkbox"/>		<input type="checkbox"/>		IF UNDER 1 YEAR	
WIDOWED		DIVORCED		IF UNDER 24 HR	
<input type="checkbox"/>		<input type="checkbox"/>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
laborer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Perry T. Russell		Margaret M. Campbell		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address	
(If yes, give war or dates of service)					
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED?	
Mary Russell (wife)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Coronary Occlusion		DUE TO			
420.1		Conditions, if any, which gave rise to immediate cause (b)			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/59		DATE SIGNED 1/19/59	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion.,		22d. LOCATION (City, town, or county) Mt. Zion, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 21 '59	
				24b. REGISTRAR'S SIGNATURE <i>Ervin S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

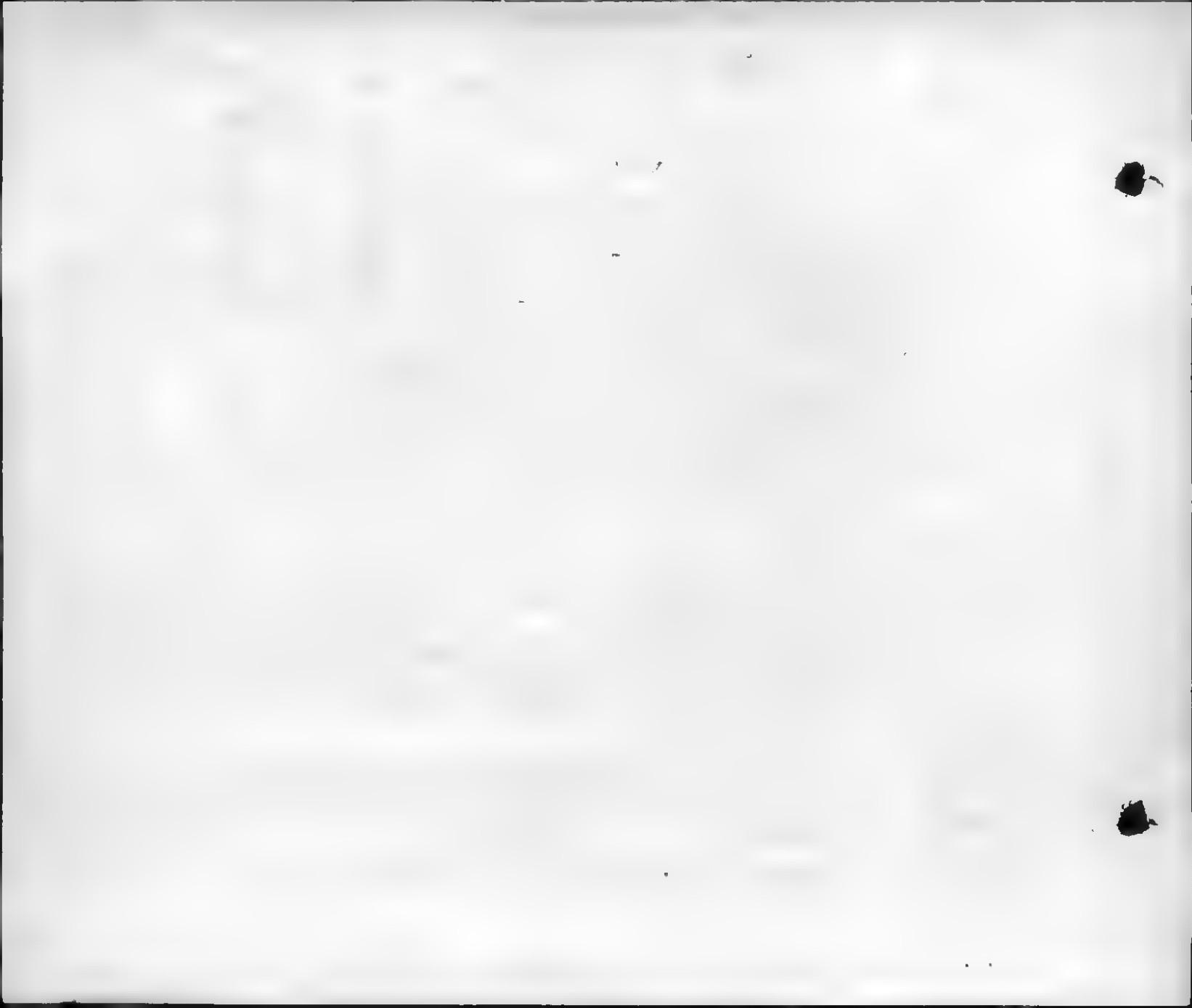
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before adm ission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN TB 47 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SARAH	Middle -	Last SCAGGS	4. DATE OF DEATH JANUARY 6 1959	Month JANUARY	Day 6	Year 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-22-1875	9. AGE (In years less birthday) 83 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min'	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME John Wesley Moore				14. MOTHER'S MAIDEN NAME Mary Cissel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Phillip Moore, Silver Spring, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic myocardial failure</i>		DUE TO <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Malnutrition + Secondary anemia</i>		DUE TO (c)		5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition + Secondary anemia</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. January 5 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highland, Md		20f. (City or town) Highland, Md	(County) Clarksville, Maryland
21. I certify that I attended the deceased from Jan 5, 1959 to January 6, 1959 , that I last saw the deceased alive on January 5, 1959 , and that death occurred at 11:47 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Highland, Md		DATE SIGNED Charles S. Whitaker	
ACTUAL SIGNATURE Charles S. Whitaker							
PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.				CLARKSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Marks		22d. LOCATION (City, town, or county) Highland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR JAN 8 '59		24b. REGISTRAR'S SIGNATURE C. S. Whitaker	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00919

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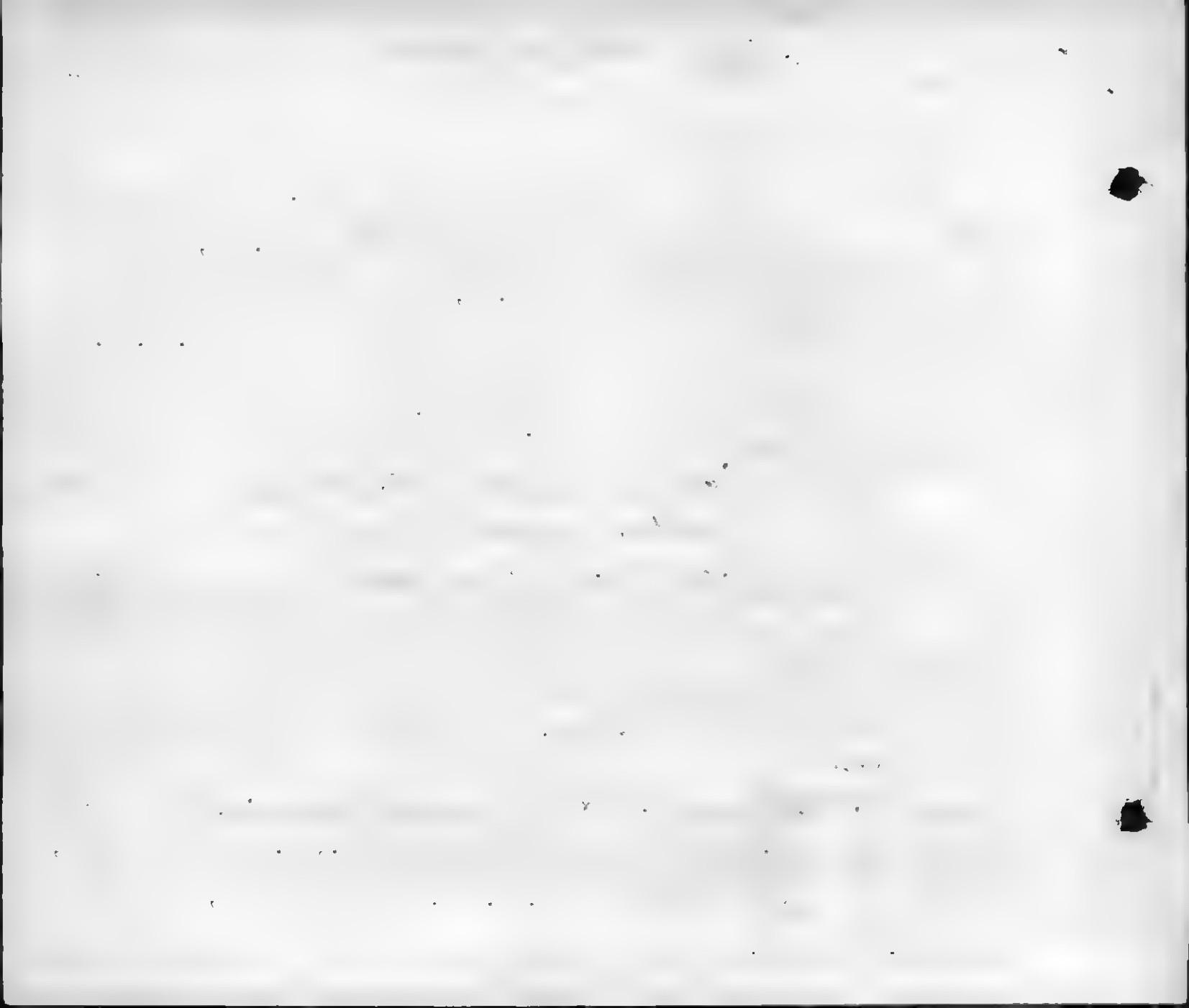
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 4104 Franklin St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall				d. STREET ADDRESS 4104 Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First META	Middle COCHRANE	Last SCANTLIN	4. DATE OF DEATH Jan. 17,	Month Jan.	Day 17	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR 10 Months	IF UNDER 24 HRS. 16 Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles Rufus Cochrane		14. MOTHER'S MAIDEN NAME Jennie Sanford						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daug. Mrs. Roland Rice		Address Same as Item #2		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia INTERVAL BETWEEN ONSET AND DEATH 3 months</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cerebral arteriosclerosis 24 years</p> <p>(c) Gonococcal arteriosclerosis 57 years</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 3000 Dent Pl., N. W., Washington, DC		(County) DC (State) DC
<p>21. I certify that I attended the deceased from Oct 29, 1958, to Jan 17, 1959, that I last saw the deceased alive on Jan 17, 1959, and that death occurred at 8:00 P. M., from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE Stephen R. Hulbert M.D. ADDRESS (Street, city or town, state) 3000 Dent Pl., N. W., Washington, DC DATE SIGNED 1-18-59</p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-59		22c. NAME OF CEMETERY OR CREMATORIUM Baldwin Meth. Ch. Cem.		22d. LOCATION (City, town, or county) Millersville, Maryland (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 22 1959		24b. REGISTRAR'S SIGNATURE John J. Flanagan		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
923 CERTIFICATE OF DEATH

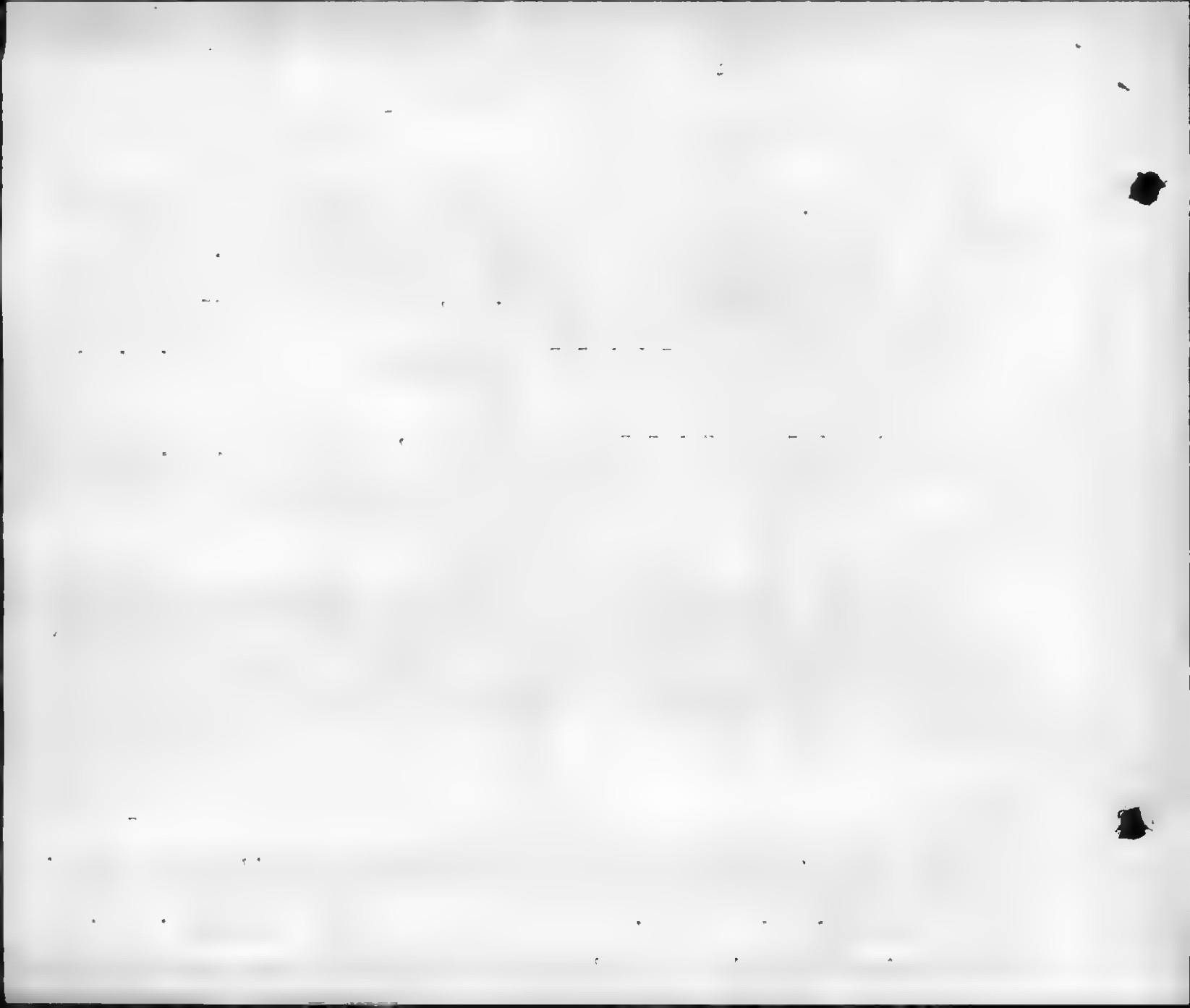
00924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland - Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest San.		e. STREET ADDRESS 3219 Coquelin Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLAXIE	Middle EVA	Last SCATES	4. DATE OF DEATH Jan. 29,	Month Day Year Jan. 29, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1883	9. AGE (In years last birthday) 76 yr.	IF UNDER 1 YEAR 12 months IF UNDER 24 HRS. 12 hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Andrew Connally		14. MOTHER'S MAIDEN NAME Charlotte Sanders		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Lyndon Scates, 3210 Coquelin Terrace Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Arteriosclerosis, general		ADDRESS INTERVAL BETWEEN ONSET AND DEATH years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -----		(b) DUE TO -----			
(c) -----					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1, 1957 to Jan. 29, 1959 , that I last saw the deceased alive on Jan. 29, 1959 , and that death occurred at 6 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 1-29-59	
ACTUAL SIGNATURE Leo M. Curtis					
PHYSICIAN'S NAME (Type) Leo M. CURTIS		8218 Wisconsin Ave., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	
22d. LOCATION (City, town, or county) Prince George Co., Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 30 '59	
				24b. REGISTRAR'S SIGNATURE C. Davis & Associates	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00921

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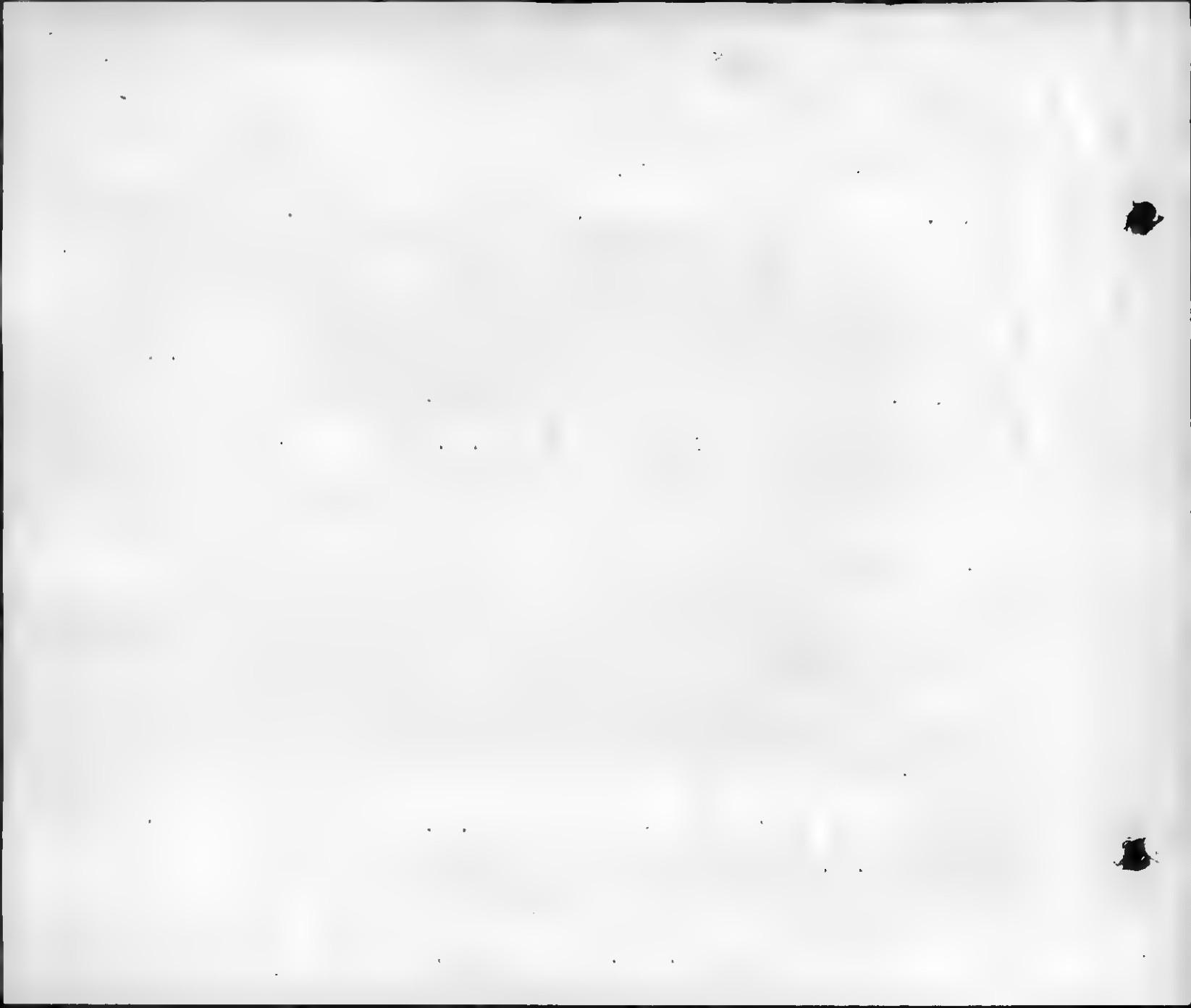
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pennsylvania		b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conshohocken		d. STREET ADDRESS 417 Spring Mill Ave.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thelma		First Thelma	Middle Mae	Last SCHMEIG	4. DATE OF DEATH January 15 1959	Month January	Day 15	Year 1959		
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-13	9. AGE (In years (at birthday) 45 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME Lewis E. Boswell				14. MOTHER'S MAIDEN NAME Mary M. Lightkep						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (1st, no. or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service) 181-10-7331		17. INFORMANT (H) Edw. J. Schmeig, same as #2 above		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma						INTERVAL BETWEEN ONSET AND DEATH 26 months				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO								
{		DUE TO								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) U. S. Naval Hospital		(State)		
21. I certify that I attended the deceased from January 2, 1959 , to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 8:46A M , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE <i>J. W. Davis</i>		M.D.		U. S. Naval Hospital		DATE SIGNED 1-15-59				
PHYSICIAN'S NAME (Type) J. W. DAVIS, LT, MC, USN		Bethesda 14, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 1-16-59		22b. DATE THEREOF 1-16-59		22c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery		22d. LOCATION (City, town, or county) Norristown		(State) Pa		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Adams Funeral Home</i>		ADDRESS 4748 Wisconsin Ave., NW, Wash. D.C.		24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE <i>John J. Adams</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00922

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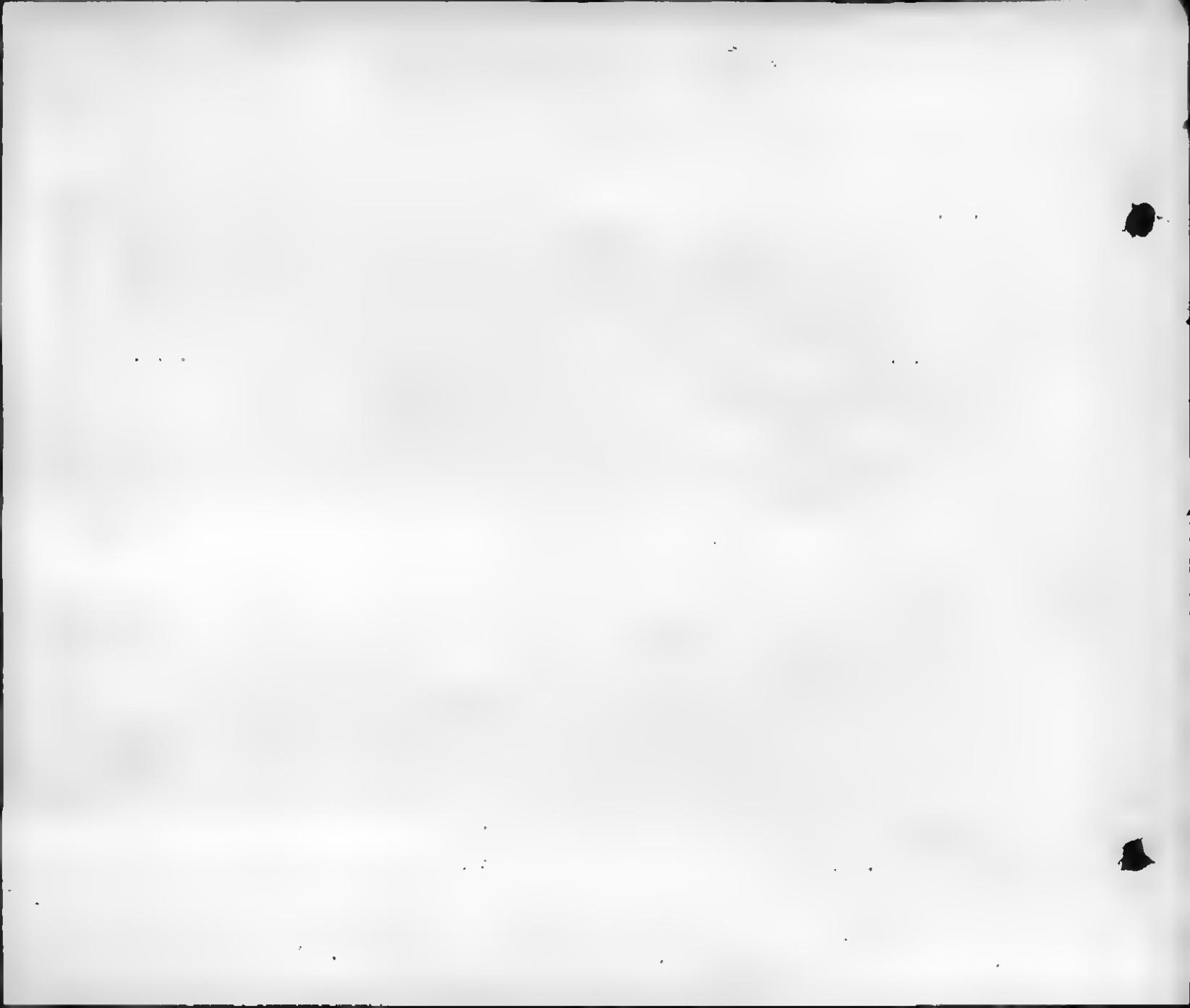
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Massachusetts		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Hunter Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Albert	Middle Richardson	Last SCHOFIELD	4. DATE OF DEATH	Month January	Day 23	Year 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11-22-94	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Joseph Anderson Schofield				14. MOTHER'S MAIDEN NAME Clare BRADDOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WVI		17. INFORMANT None		Address Mrs. Helen Manning, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO Pemphigoid skin reaction with secondary (c) staphylococcal infection Unknown 6 mos. INTERVAL BETWEEN ONSET AND DEATH 6 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple sclerosis - 25 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from November 14, 1958, to January 23, 1959, that I last saw the deceased alive on January 23, 1959, and that death occurred at 12:05 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 1-23-58							
ACTUAL SIGNATURE <i>J. T. Horgan</i>	M.D. U. S. Naval Hospital, NNM						
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN	Bethesda 14, Maryland						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 1-27-59	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National			22d. LOCATION (City, town, or county) Arlington		
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 27 '59	24b. REGISTRAR'S SIGNATURE C. L. K. 2/1/59		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4) may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



UC923

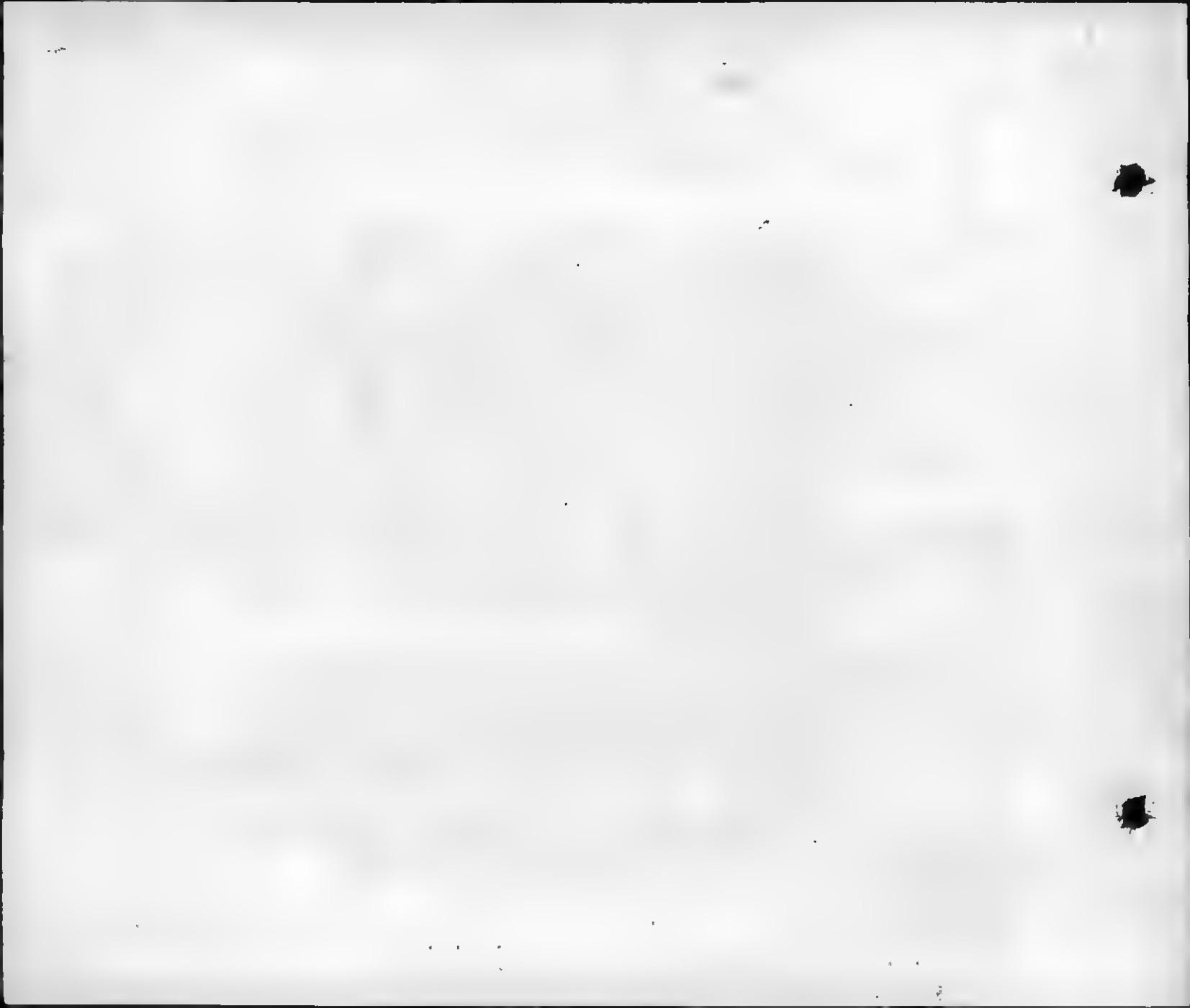
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE
HEALTH DEPT.**

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMA. Page 5 may be retained by the funeral director. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		782		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Montgomery		MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park.		1 hr. 55 min		Silver Spring Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? NO <input checked="" type="checkbox"/>	
Washington Sanitarium + Hosp'		1307 Dilston Rd S.S. Mates		f. Month Day Year	
3. NAME OF DECEASED (Type or print)		First	Middle	g. DATE OF DEATH	Month Day Year
Helen Gladys Sengstack				10-18-88	1 17 1959
5. SEX		6 COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife.				Delaware	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George G. Rowe		Kate Titus		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		Address 7920 1/2 Av., N.W., Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
DUE TO Coronary occlusion					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)					
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		<i>Frank J. Bloschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		FLANK J. Bloschart		DATE SIGNED <i>1-17-59</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
burial		1/20/59		Ft. Lincoln Cemetery Prince George, Md.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company Washington 9, D.C.					
ADDRESS 2901 14th St. N.W. REC'D BY REGISTRAR JAN 20 '59 DATE					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00924

783

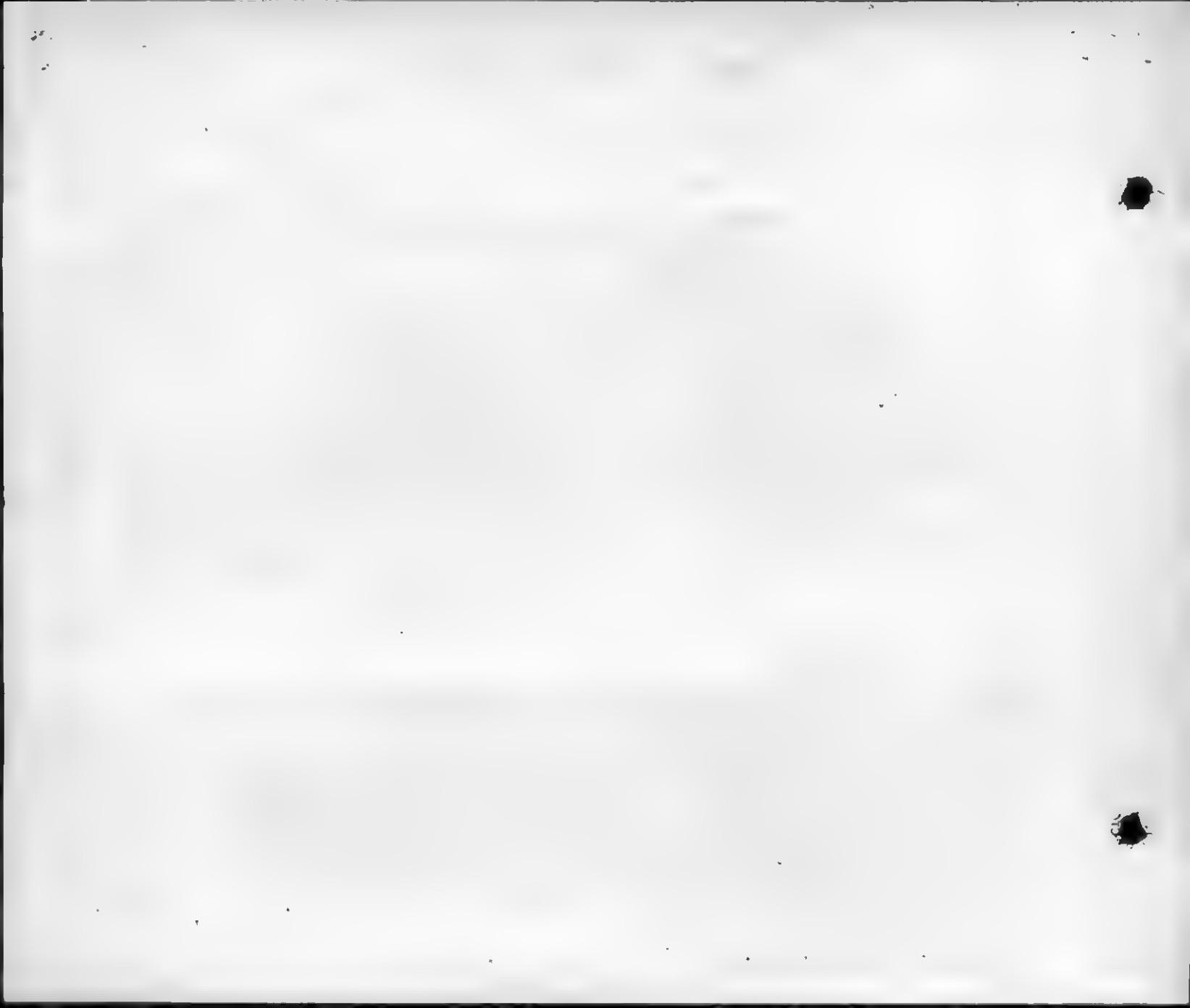
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Taxi-mew Park</i>		c. LENGTH OF STAY IN 1b <i>3 1/2 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		d. STREET ADDRESS <i>8457 Piney Br. Ct</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Randolph Barksdale Shackelford</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan. 25 1959</i>	Month	Day	Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-6-90</i>	9. AGE (In years last birthday) <i>68 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boss & Phelps</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>Willie W. Shackelford</i>		14. MOTHER'S MAIDEN NAME <i>Susan Barksdale</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>medical records</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>40.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchogenic carcinoma, right lung.</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>J. T. Kimble M.D.</i> DATE SIGNED <i>1/28/59</i>								
PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/28/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MARYLAND</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Kiernan</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

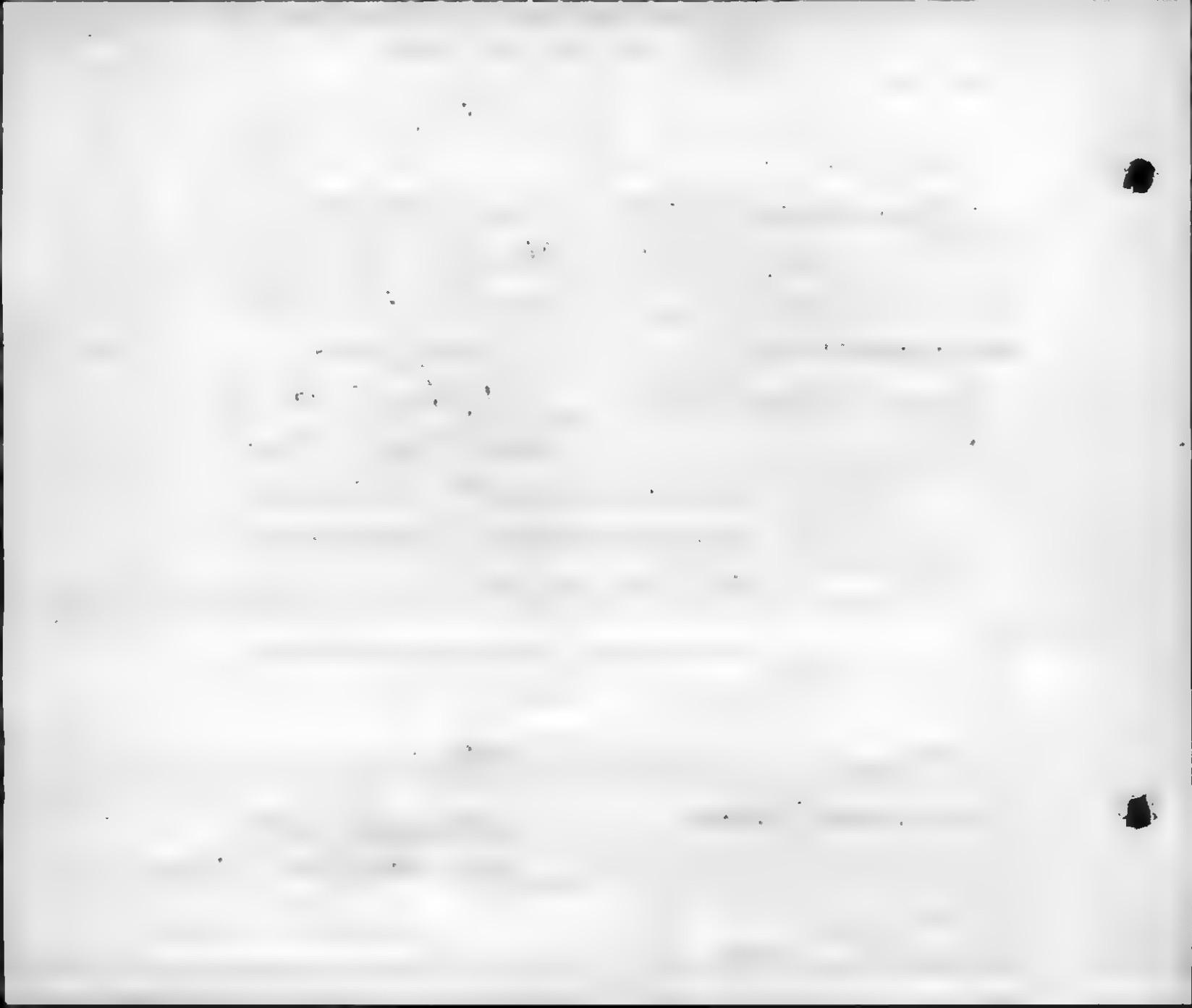
926 CERTIFICATE OF DEATH

Reg. Dist. No.

00925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. LENGTH OF STAY IN 1b 10 YRS	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION ASBURY Methodist Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIZZLEBURG	
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH JAN 3 1959	
First MARY		Middle E	
Last SHAFFER		Month JAN	Day 3
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 17 1871	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0	
11. IF UNDER 24 HRS. Days 0		12. IF UNDER 24 HRS. Hours 0	
13. FATHER'S NAME Wm. L Shaffer		14. MOTHER'S MAIDEN NAME Lydia C Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Address	
17. INFORMANT Arthur J. Shaffer, Home Recorder		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO 150.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) ARTEROSCLEROSIS	
		INTERVAL BETWEEN ONSET AND DEATH 1-2-59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV , 1958 to JAN 3 , 1959, that I last saw the deceased alive on JAN 2 , 1959, and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 10128 CEDAR LANE KENSINGTON, MD.			
ACTUAL SIGNATURE Sarah E. Glover		DATE SIGNED 1-3-59	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-59	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Church Cemetery, Gaithersburg, Md.		22d. LOCATION (City, town, or county) Towson	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest G. Hartman, Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
		24b. REGISTRAR'S SIGNATURE S. Johnson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item # FilmG237 1-1 - 19 et
927

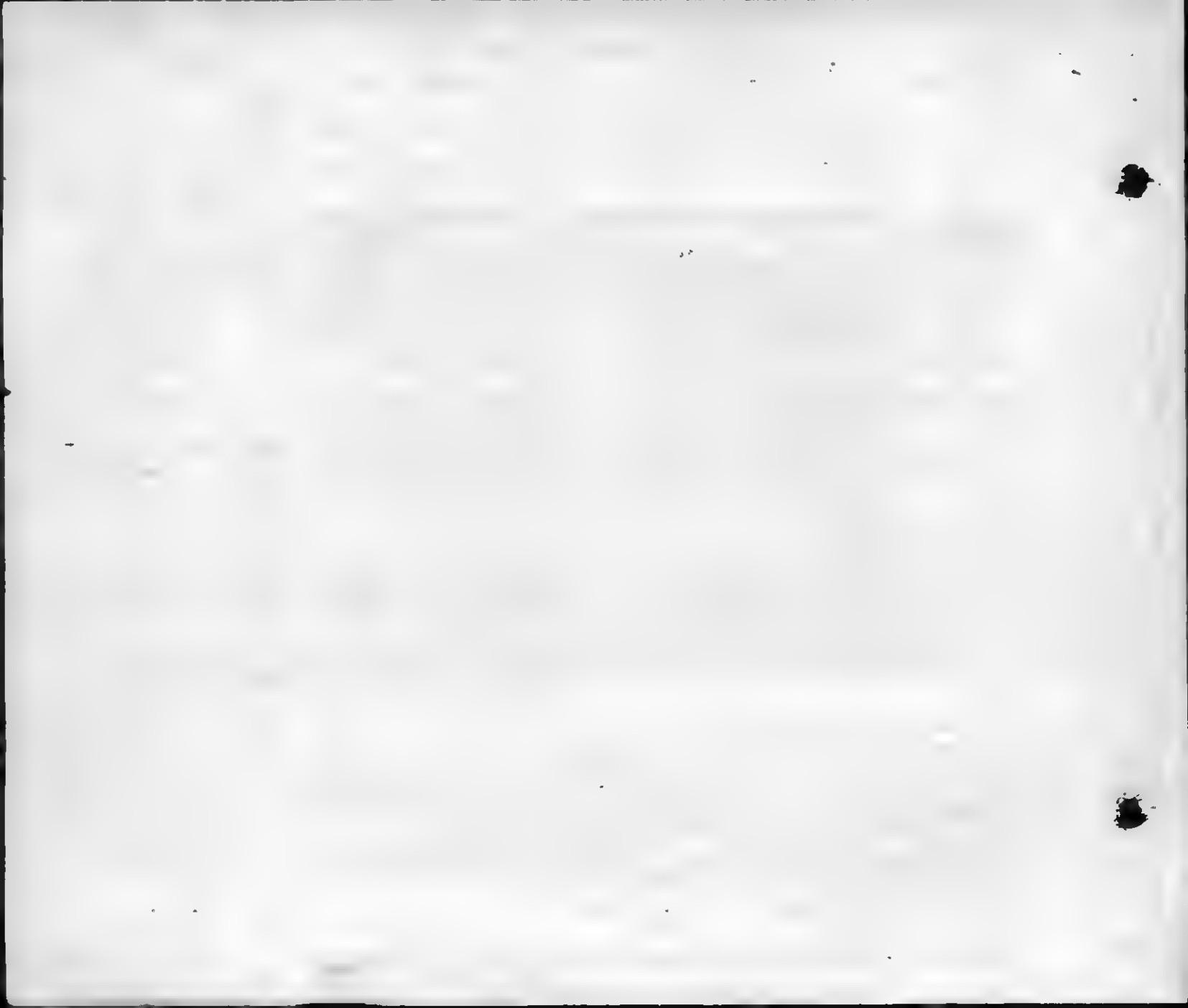
UC925

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Brenton Cemetery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. STREET ADDRESS <i>4111 Ingomar St. N.W.</i>	
f. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>J</i>		4. DATE OF DEATH Year <i>1959</i> Month <i>1</i> Day <i>2</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-29-80-78</i>	
9. AGE (In years lost birthday) <i>71 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months <i>11</i> Days <i>3</i> Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10c. BIRTHPLACE (State or foreign country) <i>D.C.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Maurice W. Quinlan</i>		14. MOTHER'S MAIDEN NAME <i>Johnna O'Conor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>John J. Sheehy Son Same</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Right hemiplegia, severe</i>		<i>6 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral thrombosis</i>		<i>6 days</i>	
DUE TO (c) <i>Arteriosclerosis, general</i>		<i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lupus erythematosis, sub acute</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pt. fell in front yard and fractured rt. clavicle</i>	
20c. TIME OF INJURY Month, Day, Year Hour (o.m.) <i>12 28 1957</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>4109 Ingomar St. N.W. DC</i>	
21. I certify that I attended the deceased from _____, 1957, to _____, 1958, that I last saw the deceased alive on _____, 1959, and that death occurred at _____, 1959, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3921 Ingomar St. N.W. DC</i>	
ACTUAL SIGNATURE <i>Stewart Clapp</i>		DATE SIGNED <i>1-2-59</i>	
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/5/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet</i>		22d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00927

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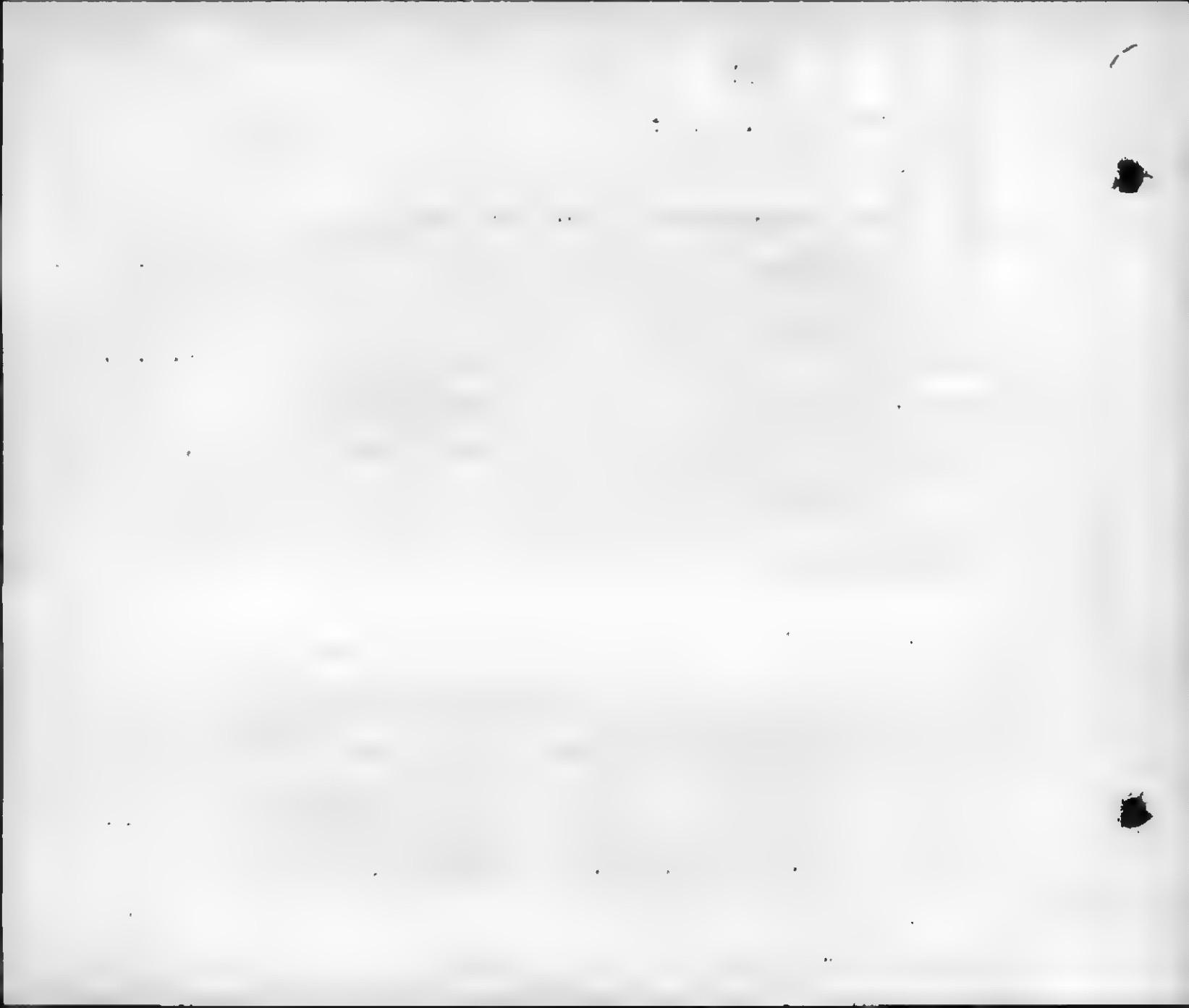
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia		b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 2024 Add Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rhoda	Middle Bertha	Last Shenk	4. DATE OF DEATH	Month January	Day 2	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1924	9. AGE (In years from birthday) 34 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS Days 4	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM Operator		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY: U. S. A.	
13. FATHER'S NAME Edwin V. Olsen				14. MOTHER'S MAIDEN NAME Rhoda Brackett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE DUE TO ACUTE LEUKEMIA				INTERVAL BETWEEN ONSET AND DEATH 4 HOURS		MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEMORRHAGE FROM RENAL PELVES							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 30, 1958 , to January 2, 1959 , that I last saw the deceased alive on January 2, 1959 , and that death occurred at 12:35 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1-2-59							
ACTUAL SIGNATURE <i>Harold R Silberman</i>		M.D. The Clinical Center 1-2-59 The National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 6, 1959		22c. NAME OF CEMETERY OR CREMATORIUM PARK LAWN Cem.		22d. LOCATION (City, town, or county) (State) BROOKLYN New York	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gabbi's Son</i>		ADDRESS 1156 PA AVE. N.W. WASH. D.C.		24a. REC'D BY REGISTRAR DATE JAN 5 1959		24b. REGISTRAR'S SIGNATURE <i>James</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		b. COUNTY <i>Mont.</i>	
c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. Hosp.</i>		d. STREET ADDRESS <i>9301 Weaver pl. Silver Spr.</i>	
3. NAME OF DECEASED (Type or print) <i>Walter Farrow</i>		First <i>W</i>	Middle <i>alter</i>
4. DATE OF DEATH <i>Jan. 20 1959</i>		Last <i>d</i>	Month <i>Jan.</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>10/27/67</i>		9. AGE (in years last birthday) <i>91</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Govt employee Govt worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>England</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Walter Suddall</i>		14. MOTHER'S MAIDEN NAME <i>Em Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>710</i>	
17. INFORMANT <i>Patient's Chart</i>		Address <i>Wash. San. Hospital</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO <i>45.0</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) <i>progressive arteriosclerosis</i> DUE TO <i>old age</i>		C years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>chronic insufficiency of kidneys, diverticulitis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Philip Morris</i>		ADDRESS (Street, city or town, state) <i>5911 16th St. N.W. Wash. D.C. 1/20/59</i>	
DATE SIGNED <i>1/20/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-23-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional</i>		22d. LOCATION (City, Town, or county) (State) <i>Wash. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS <i>48 Main Avenue</i>	
24a. REC'D BY REGISTRAR <i>JAN 22 1959</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

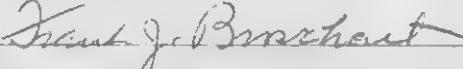


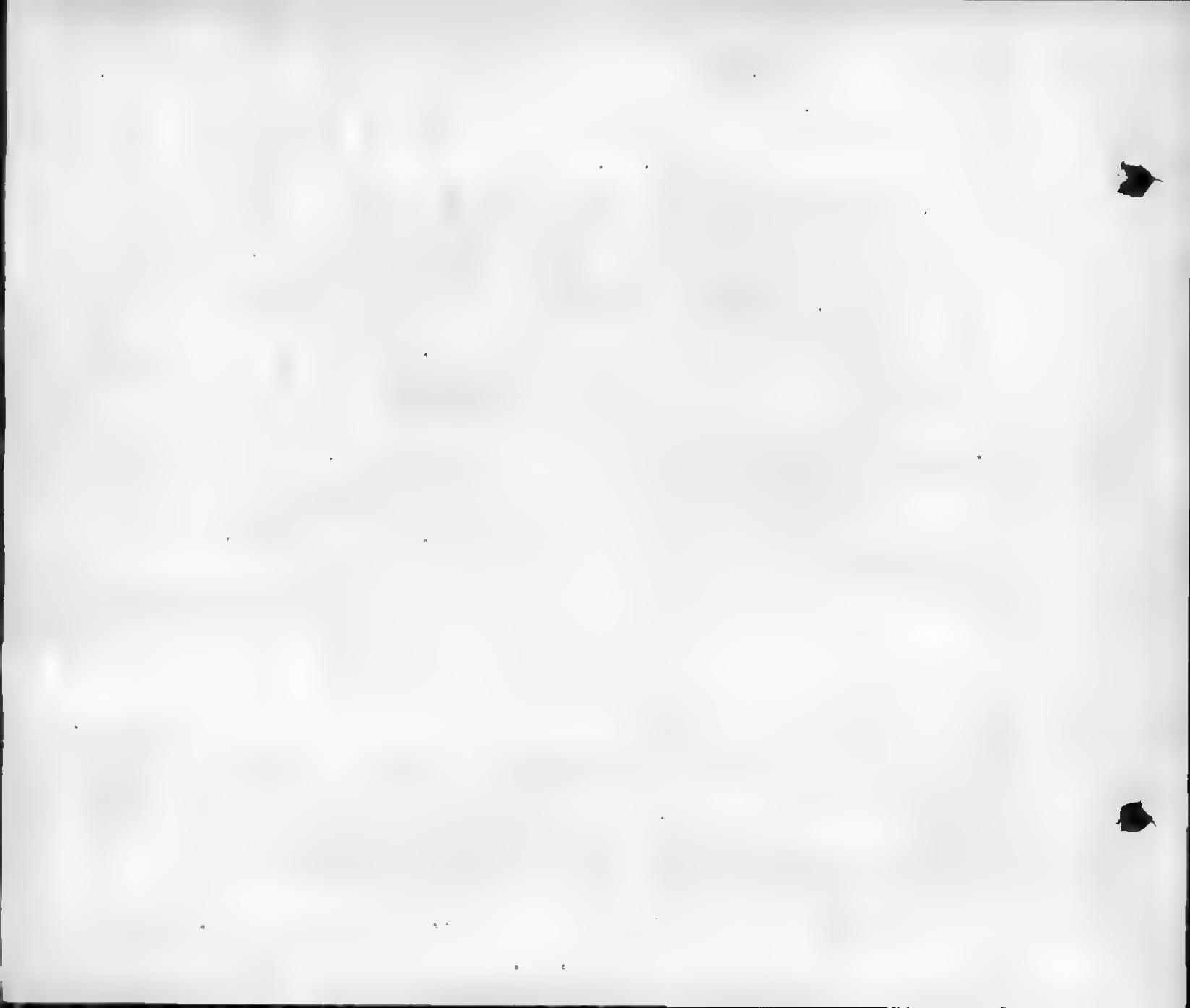
00923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

929		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney Point of Rocks	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney D.O.A.		c. LENGTH OF STAY IN Tb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.		d. STREET ADDRESS Point of Rocks	
e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard Sims		First Middle Last	4. DATE OF DEATH Jan. 23, 1959
5. SEX male		6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 2/28/1920	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Va.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sims		14. MOTHER'S MAIDEN NAME Gertrude Neuman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no. or unknown) U.S. ARMY		16. SOCIAL SECURITY NO. Police Record	
		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO Severance of left carotid A. & Lt. Jugular V.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of 2nd cervical vertebra		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger involved in auto accident	
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. 1/23/59		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	
		20e. (City or town) nr Derwood Montg. Md.	
		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 1/23/59	
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart			
22a. BURIAL CEREMONY Burial		22b. DATE THEREOF 1/27/59	
		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Baptist	
		22d. LOCATION (City, town, or county) Luckatts, Va.	
		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Rockville, Md.	
		24a. REC'D BY REGISTRAR DAW 29 '59	
		24b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00936

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-control permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		930		Reg. Dist. No.	
Montgomery		MARYLAND			
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
Silver Spring		15 yrs		a. STATE Maryland b. COUNTY Montg.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Colesville - Fairland Rd.		Silver Spring		TODAY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
Carrie B			Smith		Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
female		col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 1 1907	51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Unknown		Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
(If yes, give war or dates of service)				Stanley Smith Colesville --Fairland Rd. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure		ARRIVAL BETWEEN ONSET AND DEATH Found dead in bed			
24. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED Jan. 14, 1959
22a. BURIAL CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORIUM Ash Memorial.,	22d. LOCATION (City, town, or county) Sandy Spring, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sundeen		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE JAN 16 '59	24b. REGISTRAR'S SIGNATURE C. J. Knapp	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00931

931 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
						<input type="checkbox"/> STATE D.C. <input type="checkbox"/> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			c. LENGTH OF STAY IN lb			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47½ S			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Green Rest Home, 14326 Colesville Rd. Silver Spring, Md.						d. STREET ADDRESS 3215 Northhampton St., N.W.			
3. NAME OF DECEASED (Type or print) JULIE			First WELLS	Middle SMITH	Last 	4. DATE OF DEATH Jan. 13, 1959	Month Jan.	Day 13,	Year 1959
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1865	9. AGE (In years last birthday) 93	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Dr. Charles A. Wells			14. MOTHER'S MAIDEN NAME Mary Lucretia Hyatt			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO None			17. INFORMANT Rex C. Smith, 4520 S. Chelsea Lane, Bethesda, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X			DUE TO Chronic myocardiitis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 			(b) DUE TO Hypertension cardiac vascular disease			10 yrs			
			(c) DUE TO Coccidioidized arteriosclerosis			15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov , 1958, to Jan 13 , 1959, that I last saw the deceased alive on Jan 9 , 1959, and that death occurred at 1045PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Silver Spring			
ACTUAL SIGNATURE A. D. Bonjeant			M.D.			DATE SIGNED 1/14/59			
PHYSICIAN'S NAME (Type) A. D. Bonjeant									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Home			ADDRESS 5103 Wis. Ave., N.W. Wash. D.C.			24a. REC'D BY REGISTRAR JAN 16 1959		24b. REC'D BY STRA'S SIGNATURE 1/14/59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00932

932 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, it may be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		d. STREET ADDRESS 5425 Connecticut Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First NATHAN	Middle SONDHEIMER	Last	4. DATE OF DEATH January 25 1959	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1879	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant - Retired		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store		11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Sondheimer				14. MOTHER'S MAIDEN NAME Lena Trimpe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. Daniel Sondheimer - 5300 Elliott Rd, Westmoreland Hills, Beth.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion INTERVAL BETWEEN ONSET AND DEATH 1 hr							
400.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart disease 15 yrs							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-25 , 1959, to 1-25 , 1959, that I last saw the deceased alive on 1-25 , 1959, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John Bunker		M.D. 3701 Connaughton W.H.S. D.C. 1-2558					
PHYSICIAN'S NAME (Type) John Bunker M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington Hebrew Cong. Cem.		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE JAN 29 '59		24b. REGISTRAR'S SIGNATURE John Bunker	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00933

933

CERTIFICATE OF DEATH

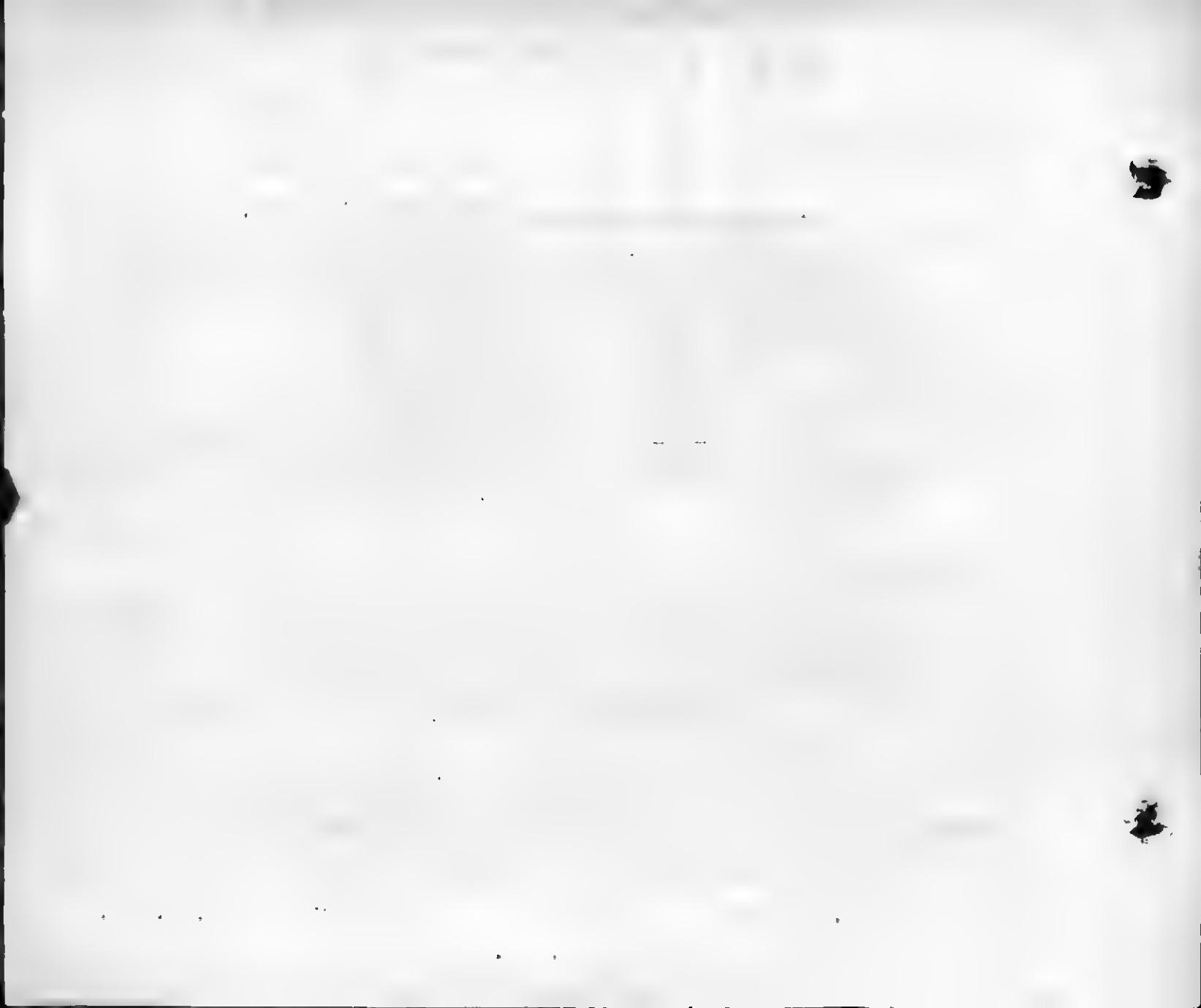
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital		d. STREET ADDRESS 25508 Woodfield Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Robert	Middle -	Last Sprague	4. DATE OF DEATH January 9 1959	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/18/16	9. AGE (In years from last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper distributor		10b. KIND OF BUSINESS OR INDUSTRY Evening Star	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Sprague		14. MOTHER'S MAIDEN NAME Isabella Younger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-5987	17. INFORMANT Hospital Records	Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1		INTERVAL BETWEEN ONSET AND DEATH 2 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Chronic alcoholism		25 years			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myelitis, undetermined type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Main Street	(County) Montgomery (State) Md.
21. I certify that I attended the deceased from 9/27/55 , 19, to 1/9/59 , 19, that I last saw the deceased alive on 1/9/59 , 19, and that death occurred at 1:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/10/59					
ACTUAL SIGNATURE <i>Dr. G. F. Meadors, M.D.</i>					
PHYSICIAN'S NAME (Type) Dr. G. F. Meadors Damaskus, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 12, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Elmwood	22d. LOCATION (City, town, or county) Shepherdstown, W. Va.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Mohrworth</i>	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR DATE JAN 13 1959	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00934

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i>		d. STREET ADDRESS <i>1167 St. Libland Av.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Anna</i>	Middle <i>Margaret</i>	Last <i>Stefford</i>	4. DATE OF DEATH	Month <i>1</i>	Day <i>14</i>	Year <i>1959</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/4/1923</i>	9. AGE (in years last birthday) <i>65</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Charles P. Swanson</i>				14. MOTHER'S MAIDEN NAME <i>MARY Munsch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>174's Hosp. Received</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>McCleaster's Carcinoma of Liver</i> DUE TO (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Colgate Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/28/58</i> , 1958, to <i>1/14/59</i> , 1959, that I last saw the deceased alive on <i>1/14/59</i> , 1959, and that death occurred at <i>Colgate Md.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Colgate Md.</i>							
DATE SIGNED <i>1/15/59</i>							
ACTUAL SIGNATURE <i>Robert F. Herk MD</i>		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL 1/17/59</i>		22b. DATE THEREOF <i>1/17/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>OAK TOWN</i>		22d. LOCATION (City, town, or county) (State) <i>COLGATE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hubert Lund Home 2112 Dundalk</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. J. Herk, Jr.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.



18

**FOR STATE
HEALTH DEPT.**

Items 18&19 Film 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. _____

00935

934

1 PLACE OF DEATH
 a. COUNTY **Montgomery** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kensington**

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **5309 Bangor Dr.**

e. IS RELATIVE ON A FARM?
 YES NO

**3. NAME OF
DECEASED
(Type or print)** **Harold** First **g G** Middle **Sta gg** Last

**4 DATE
OF
DEATH** **Jan. 15, 1959**

5. SEX **Mr. le** **white** **6 COLOR OR RACE** **7 MARRIED** **NEVER MARRIED** **8 DATE OF BIRTH** **3/8/1906** **9 AGE (In years
last birthday)** **52 yrs**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Public Relations**

10b. KIND OF BUSINESS OR INDUSTRY **Self-employed**

10c. BIRTHPLACE (State or foreign country) **Connecticut**

10d. IF UNDER 1 YEAR **10 Months** **10 Days** **10 Hours** **10 Min**

10e. IF UNDER 24 HRS

11. CITIZEN OF WHAT COUNTRY? **US**

12. MOTHER'S NAME **Elizabeth Berry**

13. FATHER'S NAME **Robert Stagg**

14. MOTHER'S MAIDEN NAME **Address**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? **No** **16. SOCIAL SECURITY NO.** **040-03-3817** **17. INFORMANT** **June W. Stagg-wife-same as 2d**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Asphyxia**
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
DUE TO
cause lost.
(c) **.14% ethyl alcohol and 2.32 mg% barbituate**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? **YES** **NO**

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY **Month, Day, Year** **Hour** **o. m.** **p. m.** **19**

20d. INJURY OCCURRED **White at work** **Not white at work**

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) **(County)** **(State)**

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE **Frank J. Broschart** **DATE SIGNED**

EXAMINER'S NAME (Type) **Frank J. Broschart**

M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER **Jan. 16, 1959**

22a. BURIAL OR CREMATION, 22b. DATE THEREOF **Bur-Transit 1/19/59**

22c. NAME OF CEMETERY OR CREMATORIUM **New Haven**

22d. LOCATION (City, town, or county) **New Haven, Connecticut** **(State)**

23. FUNERAL DIRECTOR'S SIGNATURE **Robert A. Pumphrey Bethesda, Maryland**

24a. REC'D BY REGISTRAR **JAN 20 '59** **24b. REGISTRAR'S SIGNATURE** **Civil & Funeral**

VS. A15ME
BM 2 57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00935

935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>MONTGOMERY</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		d. STREET ADDRESS <i>604-MCCARTHY AVE</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>MARY Elizabeth Sherrill</i>		First	Middle	Last	4. DATE OF DEATH JAN. 1	Month	Day	Year 1959
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 23-1910</i>	9. AGE (In years lost birthday) <i>48 yrs.</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMEMAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>NEW YORK, NY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles H. Perrine</i>		14. MOTHER'S MAIDEN NAME <i>Lorraine OLA EARLY</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>NONE</i>		17. INFORMANT <i>George Franklin Sherrill - Husband</i>		Address <i>4414</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Peritonitis, severe, acute, with thickening of appendix</i>		DUE TO <i>Infarction of ileum</i>		INTERVAL BETWEEN ONSET AND DEATH <i>23 da</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>None</i>		DUE TO <i>Volvulus of ileum</i>		INTERVAL BETWEEN ONSET AND DEATH <i>23 da</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Adhesions secondary to surgical procedure</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1/1/58</i> to <i>1/1/59</i> , that I last saw the deceased alive on <i>Jan 1, 1959</i> , and that death occurred at <i>215A M</i> , from the causes and on the date stated above				ADDRESS (Street, city or town, state) <i>John O. Robben M.D. 7930 GEORGIA AV 155 bldg 1958</i>		DATE SIGNED <i>1/1/59</i>		
ACTUAL SIGNATURE <i>John O. Robben M.D.</i>		PHYSICIAN'S NAME (Type) <i>John O. Robben M.D. 7930 GEORGIA AV 155 bldg 1958</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL <i>1/3/59</i>		22b. DATE THEREOF <i>1/3/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MD.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond L. Brooks</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE <i>John H. ...</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

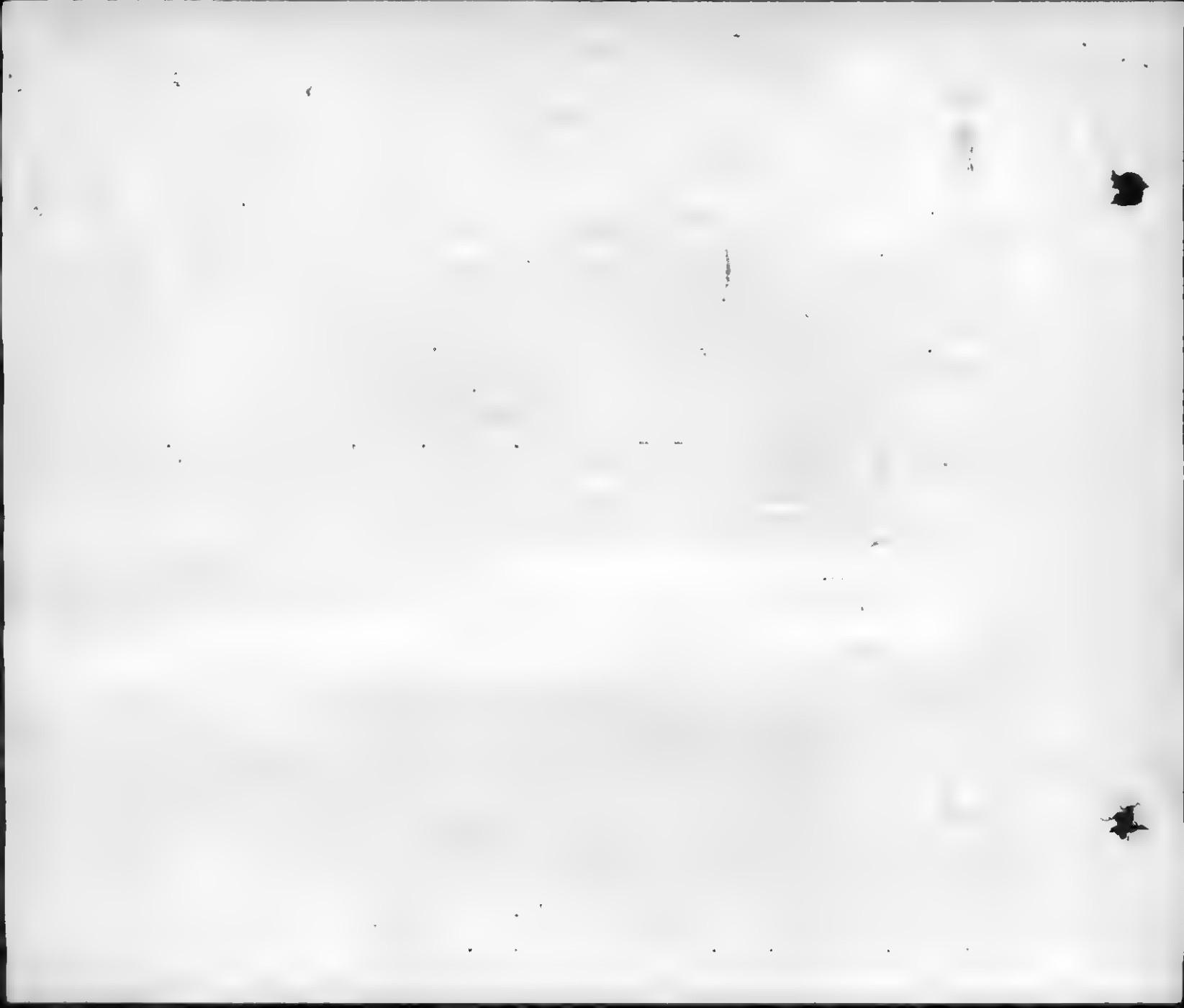
00937

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PK3. Page 3 may be retained by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

\$35													
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE											
Montgomery		MARYLAND		b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Silver Spring		7 mo		Silver Spring									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS PE IDENTIFIED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
1100 Spring St.		1100 Spring St.		f. DATE OF DEATH									
3. NAME OF DECEASED (Type or print)		First	Middle	g. DATE OF BIRTH	h. AGE (In years last birthday)								
Walter C. Charles		Stewart	Stewart	11/10/02	56 yrs								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.			
Male		White				11/10/02		56 yrs		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Salesman		Dept. store		Omaha, Nebraska		21. S. Ca							
13. FATHER'S NAME WILLIS WARDER STEWART		14. MOTHER'S MAIDEN NAME CELIA BESSIE WARNE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give nos. or dates of service)		17. INFORMANT		Address			
YES		IW #2		553-09-4070		Mrs. Ruth W. Howe, 5024 25th Ave. Hillcrest Estates, Maryland		INTERVAL BETWEEN ONSET AND DEATH		22. DIED at home on bed room floor			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Coronary occlusion											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO											
Conditions, if any, which gave rise to immediate cause (b)		DUE TO											
(c)		(d)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED	
EXAMINER'S NAME (Type)		FRANK J. BROSCHELT										1-9-59	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify)		22b. NAME OF CEMETERY OR CREMATORIUM		22c. LOCATION (City, town, or county)		(State)							
BURIAL 1/13/59		ARLINGTON NAT'L. CEMETERY		ARLINGTON, VIRGINIA									
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS		24a. REC'D BY REGISTRAR JAN 13 '59		24b. REGISTRAR'S SIGNATURE J. W. FLUMEA							
Raymond G. Ziska		SILVER SPRING, MD.		DATE									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00958

937

CERTIFICATE OF DEATH

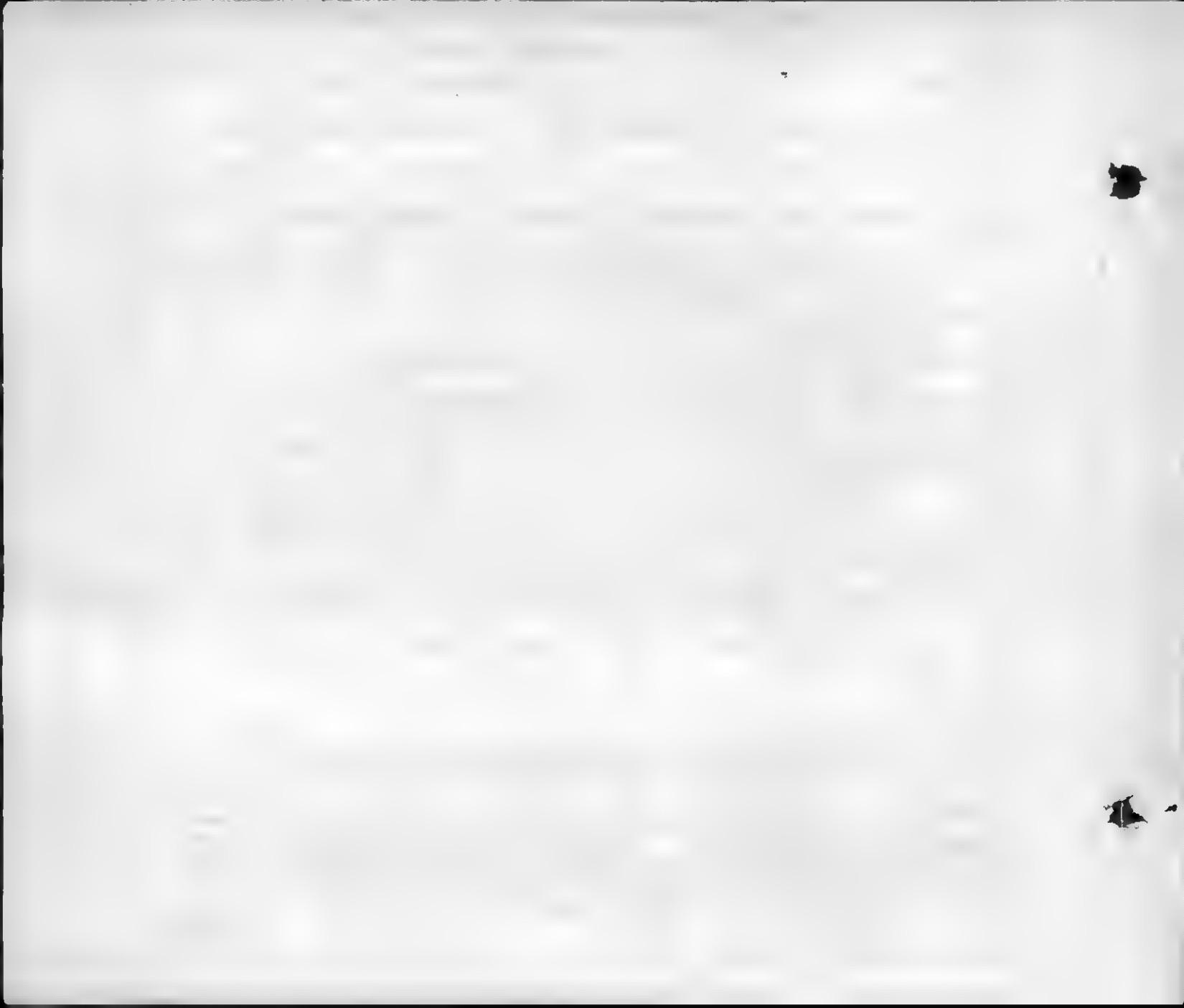
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5907 Lone Oak Drive</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>5907 Lone Oak Drive</i>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>James</i>	Middle <i>Hammond</i>	Last <i>Stone</i>	4. DATE OF DEATH <i>January 30 1959</i>	Month <i>January</i>	Day <i>30</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 30, 1882</i>	9. AGE (in years from birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Engineer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Massach</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>James Ephrим Stone</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle Hammond</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>Yes.</i>		17. INFORMANT <i>Hattie G. Stone</i>		Address <i>5907 Lone Oak Drive Bethesda Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Perforation from decubitus</i>		DUE TO (b) <i>Perforation from decubitus</i>		DUE TO (c)		2-3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1/29 1959</i> to <i>1/30 1959</i> , that I last saw the deceased alive on <i>1/20 1959</i> , and that death occurred at <i>9:20 AM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>1/30/59</i>		
ACTUAL SIGNATURE <i>Alfred E. Norton</i>		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/2/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Crem.</i>		22d. LOCATION (C'ty, town, or county) <i>Rosedale Park Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i>		ADDRESS <i>3720 Wisconsin Ave Wash DC</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 4 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Finnegan</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>5515-Mckinley St,</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lloyd</i>		First <i>E</i>	Middle <i>ward</i>	Last <i>Stonell</i>	4. DATE OF DEATH <i>Jan 1 1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 3 1886</i>	9. AGE (In years lost by birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		10c. BIRTHPLACE (State or foreign country) <i>Cumberland County Va</i>	
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		Address <i>Above</i>	
13. FATHER'S NAME <i>Timper Iver Stonell</i>		14. MOTHER'S MAIDEN NAME <i>FANNY WADE</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Colinda R. Stonell, wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Thrombosis, left ant desc. coronary Art.</i> DUE TO (b) <i>3 day</i> (c) <i>Coronary sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Charles Savarese</i> , 1955, to <i>12/31/1958</i> , that I last saw the deceased alive on <i>12/31/1958</i> , and that death occurred at <i>3:35 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles Savarese, M.D.</i> PHYSICIAN'S NAME (Type) <i>CHARLES SAVARESE MD</i>		ADDRESS (Street, city or town, state) <i>BETHESDA, MD</i>		DATE SIGNED <i>1/1/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-3-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	
22d. LOCATION (City, town or county) <i>Suitland, Maryland</i>		24a. REC'D BY REGISTRAR <i>JAN 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>S. H. M.</i>	
25. ROBBERY, KIDNAPING, SLAUGHTER <i>Robert J. Humphrey</i>		ADDRESS <i>Bethesda, Md.</i>			
VS A15 (4) 15M 9/55					

FOR ST/HEALTH C

of Health
our files.

It should be executed within 24 hours after death. If any day is "long" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral miner's Office along with form PMJ. Page 5 may be retained a burial-transit permit. File pages 1 and 2 with the State 81st at once, and in an envelope within 72 hours after death.

TO : exec
45ME
TO FIN

00940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPT.

Reg. Dist. No.

935

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN [If outside corporate limits, write RURAL
and give nearest town]

Silver Spring

c. LENGTH OF STAY IN 1b

50 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

620 Ritchie Ave

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
from today)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (State or foreign country)

13. CITIZEN OF WHAT COUNTRY?

Female

WIDOWED

DIVORCED

2-4-77

81

Yrs

IF UNDER 1 YEAR

Months

Days

Hours

Min.

13. FATHER'S NAME

Clyde Snowden

14. MOTHER'S MAIDEN NAME

Charlotte Boyd

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Bernard W. Taylor

Time 2
Interval between onset and death
sudden

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Coronary occlusion

DUE TO

Conditions, If any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20c. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.

20d. INJURY OCCURRED
While at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Borschert

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

ASSISTANT MEDICAL EXAMINER

1-4-59

DEPUTY MEDICAL EXAMINER

22a. FUNERAL DIRECTOR'S SIGNATURE
BUT 181

22b. DATE THEREOF
1/7/59

22c. NAME OF CEMETERY OR CREMATORIUM
Lincoln Park,

22d. LOCATION (City, town, or county)
Rockville, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Robert L. Snowden

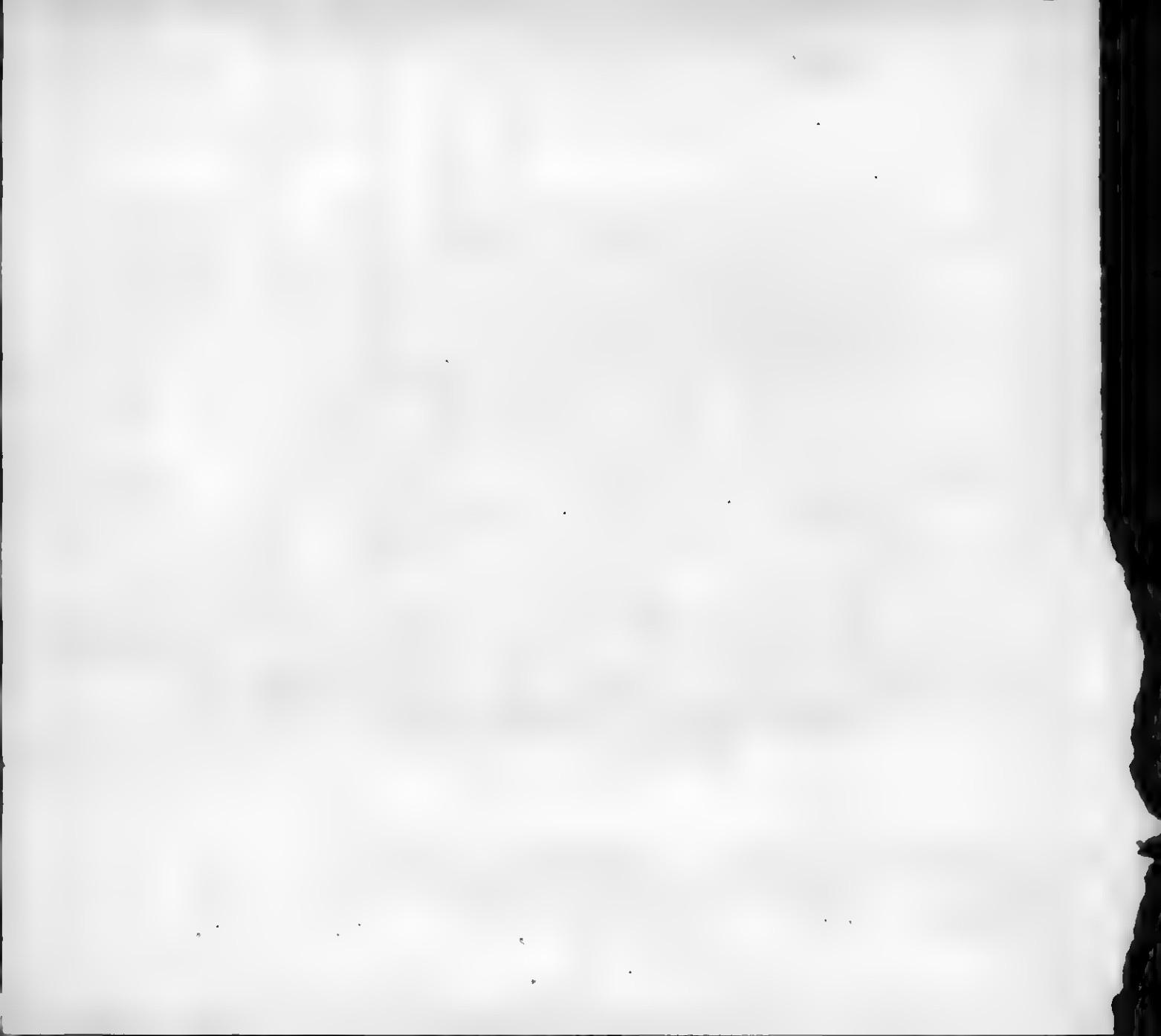
ADDRESS
Rockville, Md.

24a. REC'D BY REGISTRAR

JAN 9 '59

24b. REGISTRAR'S SIGNATURE

Frank J. Borschert



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00941

340

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 108 15th Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maxzeller		First Leonard	Middle THOMAS	Losl January 22	4. DATE OF DEATH January 22	Month January	Day 22	Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-96	9. AGE (In years lost birthday) 62 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) So. Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Charles Lee THOMAS				14. MOTHER'S MAIDEN NAME Annie THOMAS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WVI		17. INFORMANT (W) Mrs. Selma D. Thoams, same as #2 above		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 2 hrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 16, 19 59 , to January 22, 19 59 , that I last saw the deceased alive on January 22, 19 59 , and that death occurred at 8:19A M , from the causes and on the date stated above ACTUAL SIGNATURE <i>E. G. Muth</i> ADDRESS (Street, city or town, state) M.D. U. S. Naval Hospital, NNMC DATE SIGNED 1-22-59								
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial		22d. LOCATION (City, town, or county) Suitland (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hall Bros. Funeral Home</i>		ADDRESS 621 Fla. Ave, NW, Wash. DC		24a. REC'D BY REGISTRAR C. J. Hall		24b. REGISTRAR'S SIGNATURE Arthur L. Knott		
VS A15 (4) 15M 10/57		DATE JAN 26 '59						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

941

CERTIFICATE OF DEATH

00942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Gilbert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Gilbert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lansdowne - Md.</i>		e. STREET ADDRESS <i>Thompson Road - Lansdowne</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Lawrence</i>	Middle <i>Howard</i>	Last <i>Thompson</i>	4. DATE OF DEATH	Month <i>Jan</i>	Year <i>5</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 19, 1827</i>	9. AGE (In years lost birthday) <i>89 yrs</i>	10. IF UNDER 24 HRS Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Davidson Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Martha C. Thompson, Thompson Head</i>		Address <i>Lansdowne Rd.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>NONE.</i>		17. INFORMANT <i>Mr. Ruth C. Thompson, Thompson Head</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yrs 9 mos</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.3</i>		Caecumoma Segmoid					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Metastases					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bassing Spring</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/4</i> , 19 <i>58</i> , to <i>1/1/59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11/4</i> , 19 <i>59</i> , and that death occurred at <i>Bassing Spring</i> , Md., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Bassing Spring</i>		DATE SIGNED <i>1/15/59</i>	
ACTUAL SIGNATURE <i>Dr. Arthur Kates</i>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, (22b. DATE THEREOF REMOVAL (Specify)) <i>Burial Jan 7, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bass Spring Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Kates</i>		ADDRESS <i>254 Carroll St.</i>		24a. REC'D BY REGISTRAR DATE JAN 7 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur Kates</i>	

2

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

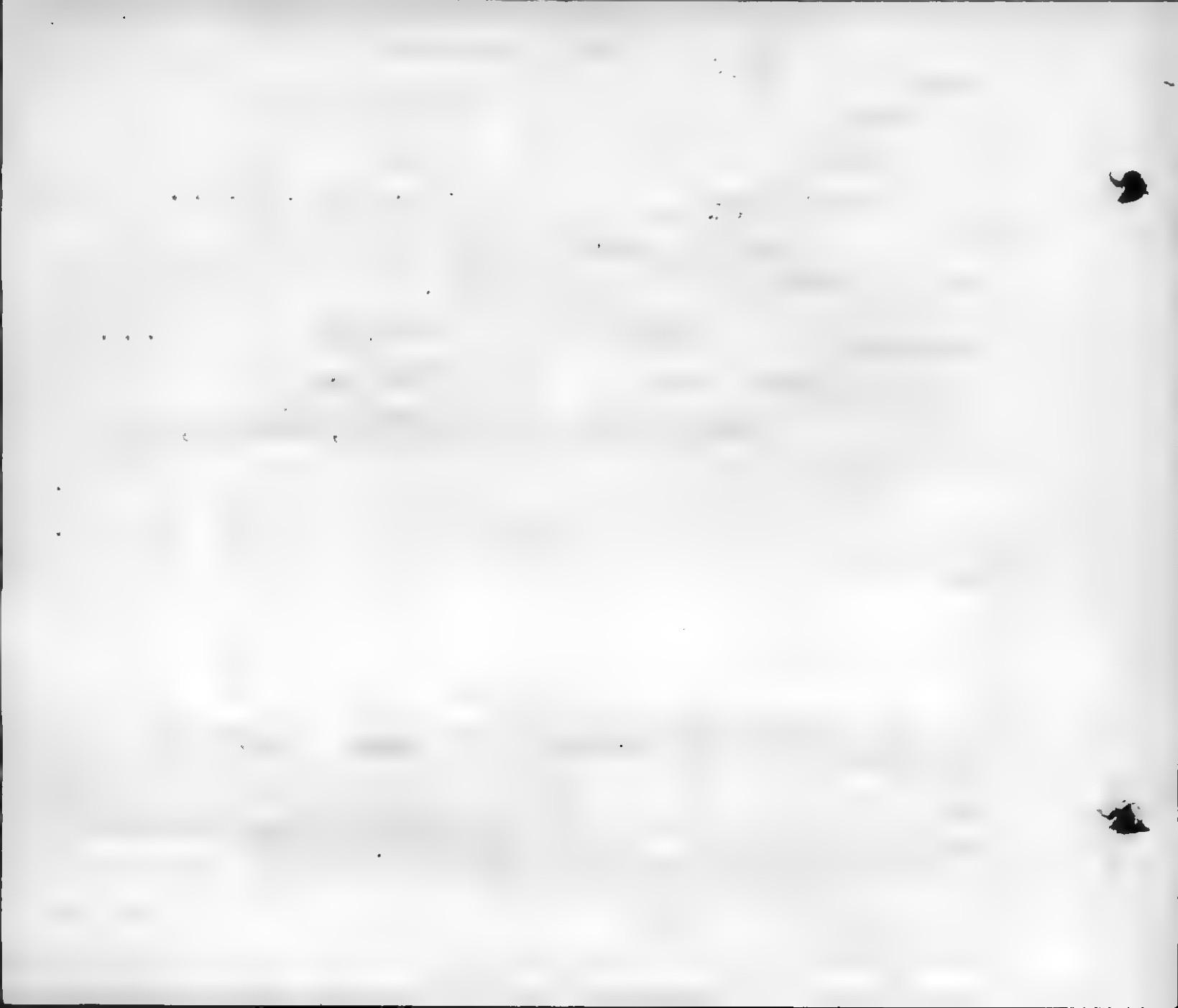
00943

042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 59 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1335 Saratoga Avenue, N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert		First Robert	Middle Pierce	Last Thompson	4. DATE OF DEATH January 26, 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 31, 1901	9. AGE (In years last birthday) 57 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Illustrator		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Ovington Thompson		14. MOTHER'S MAIDEN NAME Bertha Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema <i>443 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Hypertensive Cardiovascular Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Absence, Left Kidney				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) The Clinical Center	
20f. (City or town) Bethesda		(County) Maryland		(State) Maryland	
21. I certify that I attended the deceased from November 28, 1958 , to January 26, 1959 , that I last saw the deceased alive on January 26, 1959 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Louis Gillespie Jr.</i> M.D. The Clinical Center DATE SIGNED 1/27/59					
PHYSICIAN'S NAME (Type) LOUIS GILLESPIE, JR.		ADDRESS 1400 Clifton St 2700		ADDRESS Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORIUM Tedlar Hill Cemetery, Suitland, Maryland	
22d. LOCATION (City, town, or county) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS 1400 Clifton St 2700		24b. REC'D BY REGISTRAR OPEN 3 0 '59	
				24b. REGISTRAR'S SIGNATURE John S. Harlan	



00944

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
786 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hsp.</i>		e. STREET ADDRESS <i>5010 37th. Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Stephen Broodus Tilley</i>		4. DATE OF DEATH <i>January 9 1959</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-9-68</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Punker - Gov't.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>	10c. BIRTHPLACE (State or foreign country) <i>D.C.</i>
13. FATHER'S NAME <i>Stephen Tilley</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Sheriff</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Daughter - Chert</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tracheal Obstruction hypoxia from aspiration of vomitus.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Aspiration of vomitus</i>		(c) DUE TO <i>Esophageal Atresia - Scler Esophagus</i> <i>Several years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1950, to _____, 1959, that I last saw the deceased alive on _____, 1959, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Robert B. Irey</i>		M.D. <i>705 Ridge Rd.</i> Physiatr., Md.	
PHYSICIAN'S NAME (Type) <i>ROBERT B. IREY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/12/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cemetery Washington, D.C.</i>
22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>DAHAN 1 2 '59</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Schlesinger Co. 3614 1/2 N. L. C.</i>		24b. REGISTRAR'S SIGNATURE <i>Clara S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00945

943

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND		b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		d. STREET ADDRESS Rt. #1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB		First	Middle	Lost	4. DATE OF DEATH TRATEN	Month	Day	Year			
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1997	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANTIQUE SHOP OWNER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Fischer Trachtenberg		14. MOTHER'S MAIDEN NAME Esther Libby Frenkel									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT JEANETTE R. TRATEN		Address SAME					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 420.1										INTERVAL BETWEEN ONSET AND DEATH 2 HOUR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at DOA M, from the causes and on the date stated above										ADDRESS (Street, city or town, state) Sandy Spring, MD 20882	DATE SIGNED 1/5/55
ACTUAL SIGNATURE <i>A. D. Bonifant</i>		PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.								SANDY SPRING, MARYLAND	
22a. BURIAL-CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-59		22c. NAME OF CEMETERY OR CREMATORIUM King David Memorial Garden		22d. LOCATION (City, town, or county) Falls Church		(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE B. Lenzansky & Sons—3501 14th St., N.W., Wash., D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 8 '59		24b. REGISTRAR'S SIGNATURE <i>C. Long & Friend</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

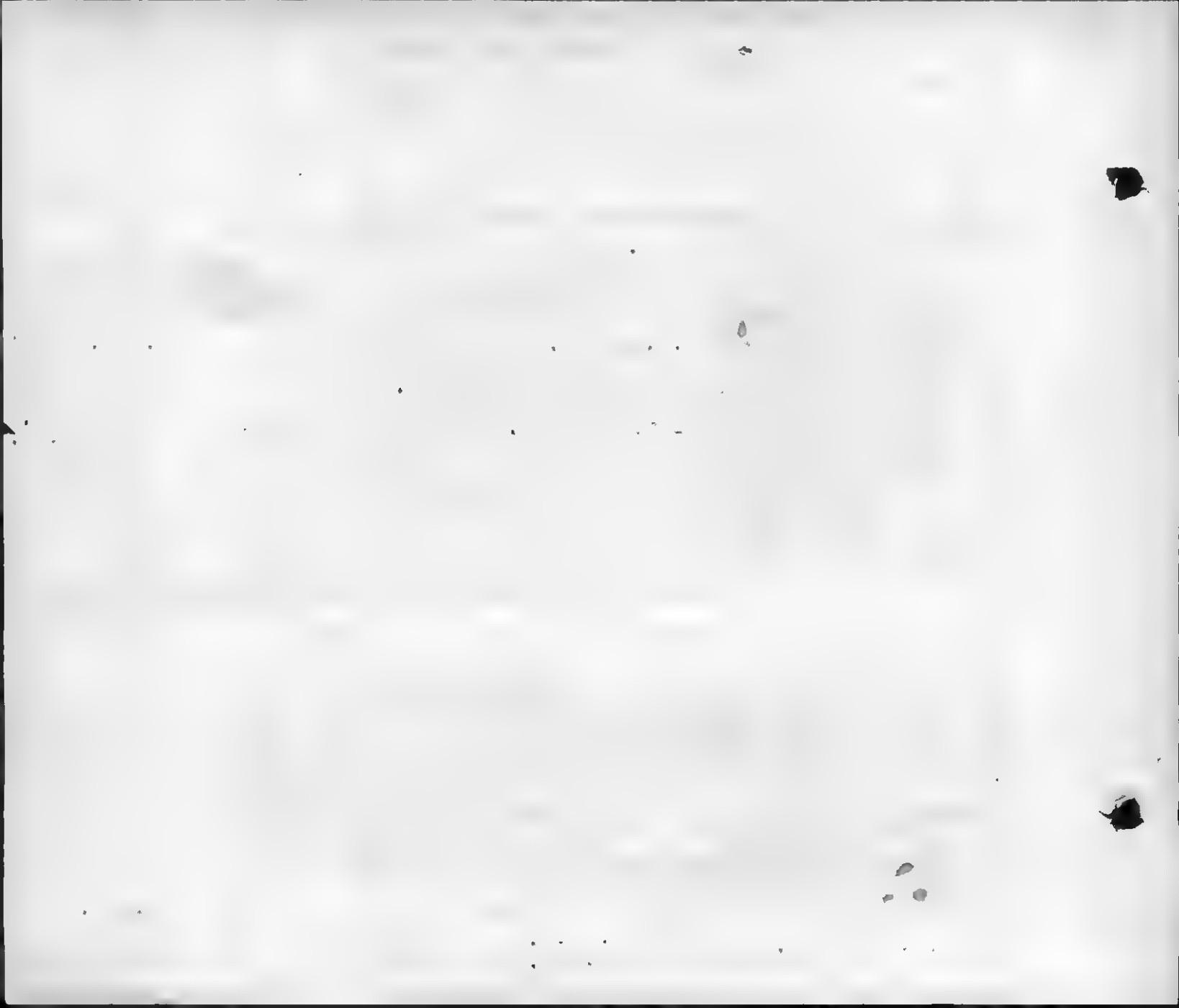
00946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write R.R.A. and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2401 Spencer Road		e. STREET ADDRESS 2401 Spencer Road	
3. NAME OF DECEASED (Type or print) FRANK V. TURNERY		4. DATE OF DEATH JANUARY 25 1959	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1910
9. AOE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Electrification-U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Albert Thorn Turnery		11. BIRTHPLACE (State or foreign country) Missouri	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 490-07-2150		17. INFORMANT Mrs. Nella Maud Turney- ^{Address} 2401 Spencer Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ADENO CARCINOMA OF LUNG</i>		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>NONE</i>	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>OCT. 7 1958</i> to <i>JAN. 25 1959</i> , that I last saw the deceased alive on <i>JANUARY 25 1959</i> , and that death occurred at <i>3:37 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Belden R. Reap, M.D.</i> ADDRESS (Street, city or town, state) <i>11502 GRANDVIEW AVE. 1125-A</i> DATE SIGNED <i>1/25/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1959	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		22d. LOCATION (City, town, or county) Montgomery County, Md. (State)	
ADDRESS 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE JAN 27 '59	24b. REGISTRAR'S SIGNATURE <i>C. J. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00947

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 4011 Dresden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Howard	Middle John	Last Twilley	4. DATE OF DEATH January 15, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1904	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Inspector		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. S. Twilley		14. MOTHER'S MAIDEN NAME Anna Baumgartner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 12X		Hepatic Coma					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Viral Hepatitis					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 8, 1958 , to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 9:00 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
ACTUAL SIGNATURE <i>James C. Kirby Jr. MD</i>		M.D.				DATE SIGNED 1/15/59	
PHYSICIAN'S NAME (Type) James C. Kirby, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 19 '59		24b. REGISTRAR'S SIGNATURE <i>Curious S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00948

946

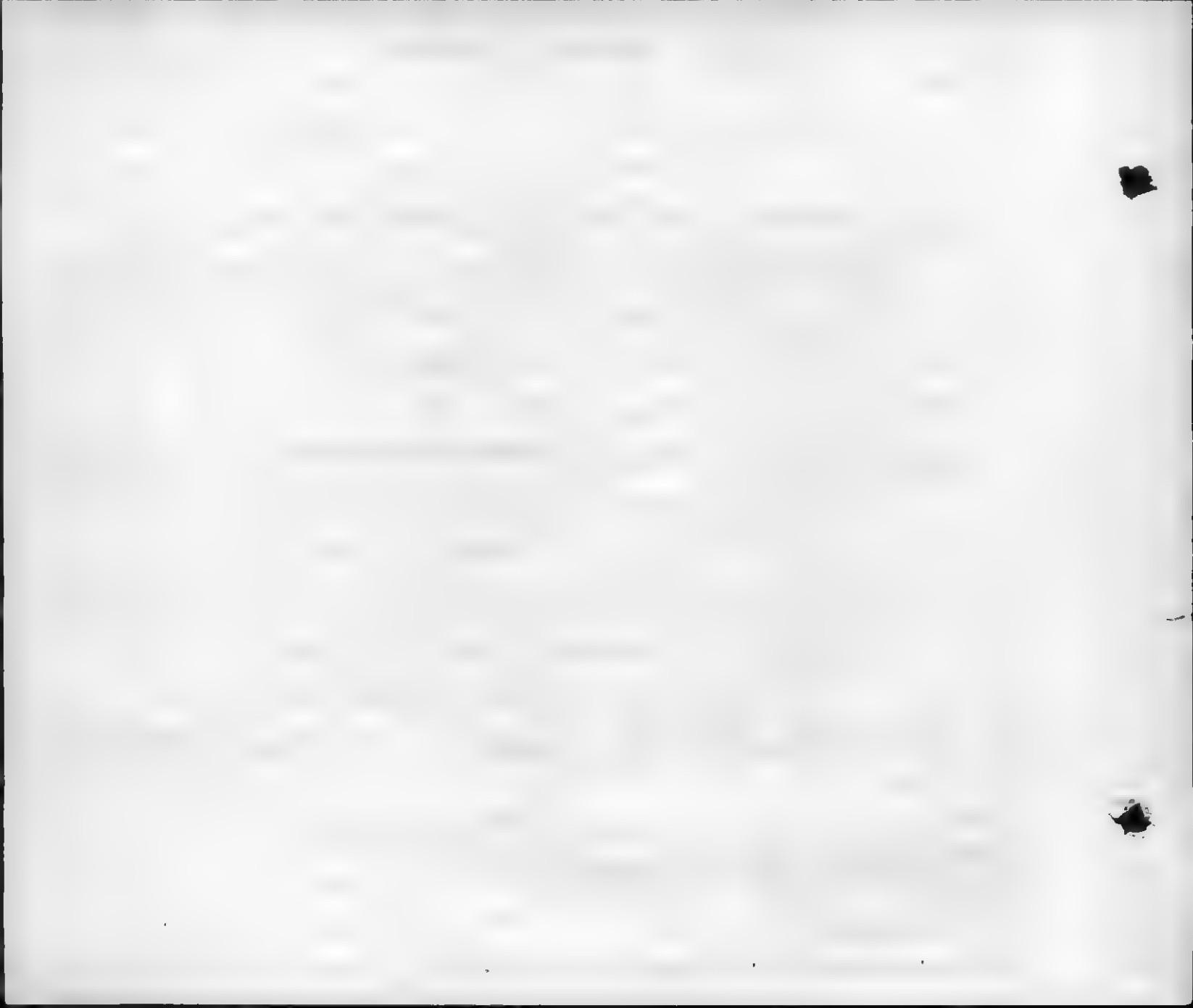
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>18 months</i>	b. COUNTY <i>Montgomery</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4890 Battery Lane Bethesda</i>	d. STREET ADDRESS <i>4890 Battery Lane</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gertrude Elizabeth Tyree</i>	First <i>G</i>	Middle <i>E</i>	Last <i>Tyree</i>
4. DATE OF DEATH <i>Jan. 22 1959</i>	Month <i>Jan.</i>	Day <i>22</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.H.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12, 1892</i>
9. AGE (In years lost, birthday) <i>66 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk U.S. Gov't.</i>	11. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't</i>	12. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>
13. FATHER'S NAME <i>William A. Donaldson</i>	14. MOTHER'S MAIDEN NAME <i>Lovisa A Plitt</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>U.S.A.I.</i>	
16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Sister Dorothy E Hayden</i>	18. ADDRESS <i>826 South Irving</i>	19. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>gasintestinal hemorrhage</i>	
DUE TO <i>Carcinoma of pancreas</i>		5 months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. j. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4890 Battery Lane, Bethesda</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept.</i> , 1958, to <i>Jan. 22</i> , 1959, that I last saw the deceased alive on <i>Jan. 21</i> , 1959, and that death occurred at <i>9 AM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Wilfred R. Ehrmantrout M.D.</i>	ADDRESS (Street, city or town, state) <i>4890 Battery Lane, Bethesda</i>		
PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmantrout M.D.</i>	DATE SIGNED <i>1/24/59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>1/24/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olivet Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington, D.C.</i>	24a. REC'D BY REGISTRAR <i>JAN 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Tolson 2nd</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Roger 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00949

347

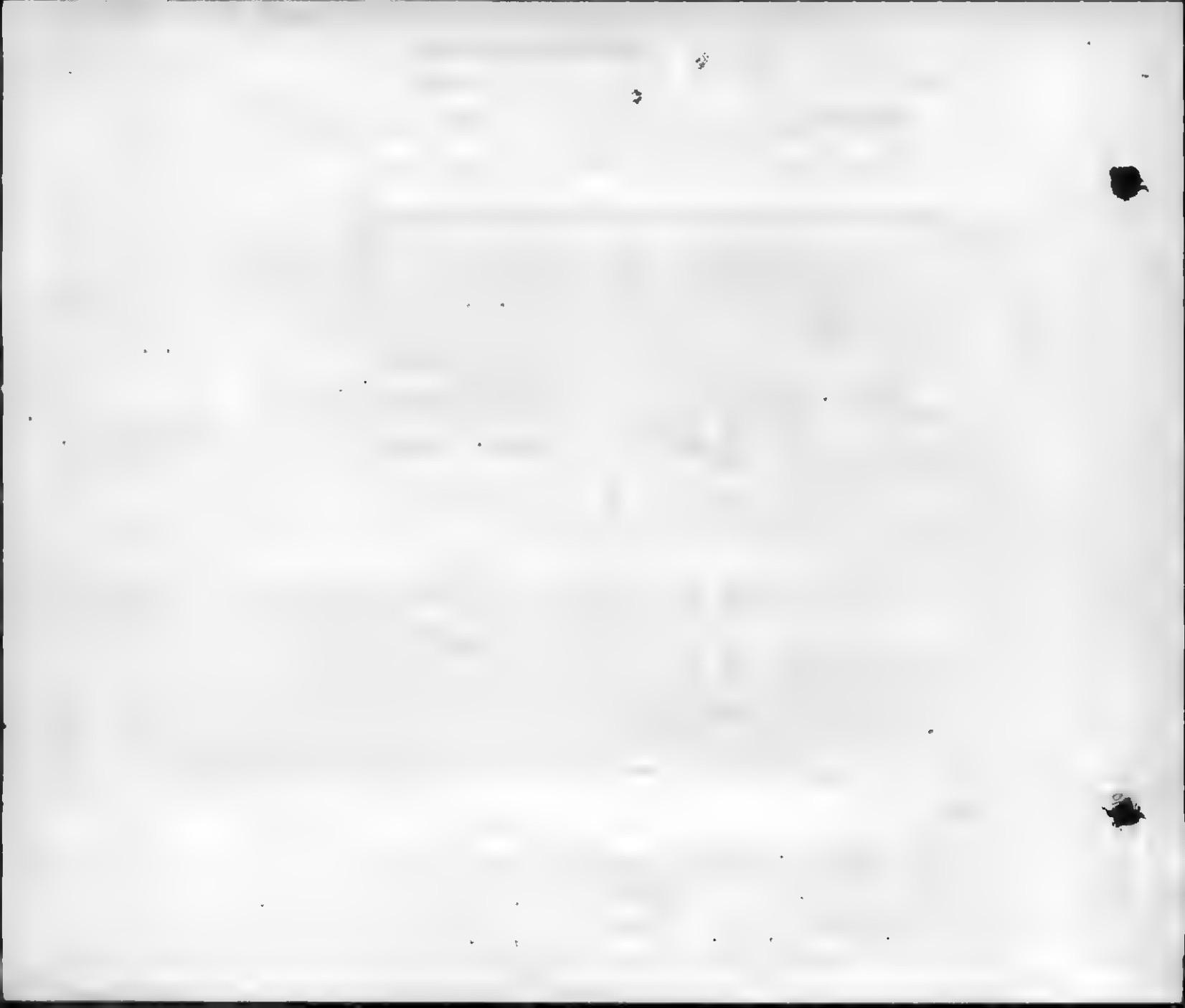
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) Michele Mary Valleix		4. DATE OF DEATH 12/31/58	Month January Day 2 Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Janxx2xx1929x
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
10c. MOTHER'S MAIDEN NAME J. Marguerite Patterson		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Louis M. Valleix		12. CITIZEN OF WHAT COUNTRY? Address 318 Broadwood Dr. Rockville, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louis M. Valleix		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atlecteria DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Immaturity DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31-58 , 19 58 , to 1-2 , 19 59 , that I last saw the deceased alive on 1-2-59 , 19 59 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Francis J. Troendle, M.D. 869 Silver Mill Rd., Rockville, Md.			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) FRANCIS J. TROENDLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/6/59	
22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
		24a. REC'D BY REGISTRAR JAN 7 1959	
		24b. REGISTRAR'S SIGNATURE Francis J. Troendle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00950

948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10510 Tinsley St.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Roscoe Sanatorium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First	Middle <i>Ann</i>	Last <i>Flanigan</i>	4. DATE OF DEATH <i>03 Jan 1959</i>	Month <i>January</i>	Day <i>24</i>	Year <i>1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 6 1876</i>		9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <i>0</i>		Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>Capt A.P. Cunningham</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ida McCubbins</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>10510 Tinsley St.</i>		17. INFORMANT <i>Son - William F. Flanigan Silver Spring, Md.</i>		Address <i>10510 Tinsley St.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>								
20a. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>generalized arteriosclerosis diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Jan 23 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4890 Battery Lane, Bethesda</i>		20f. (City or town) <i>Montgomery County, Md.</i>		(County) <i>Montgomery County, Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Jan 23 1959</i> to <i>Jan 24 1959</i> that I last saw the deceased alive on <i>Jan 23 1959</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wilfred R. Ehrmantrout</i>		ADDRESS (Street, city or town, state) <i>4890 Battery Lane, Bethesda</i>		DATE SIGNED <i>1/24/59</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/27/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven</i>		22d. LOCATION (City, town, or county) <i>Montgomery County, Md.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Harris co 2901-14 2nd St N.W.</i>		ADDRESS <i>Washington, D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Finch</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

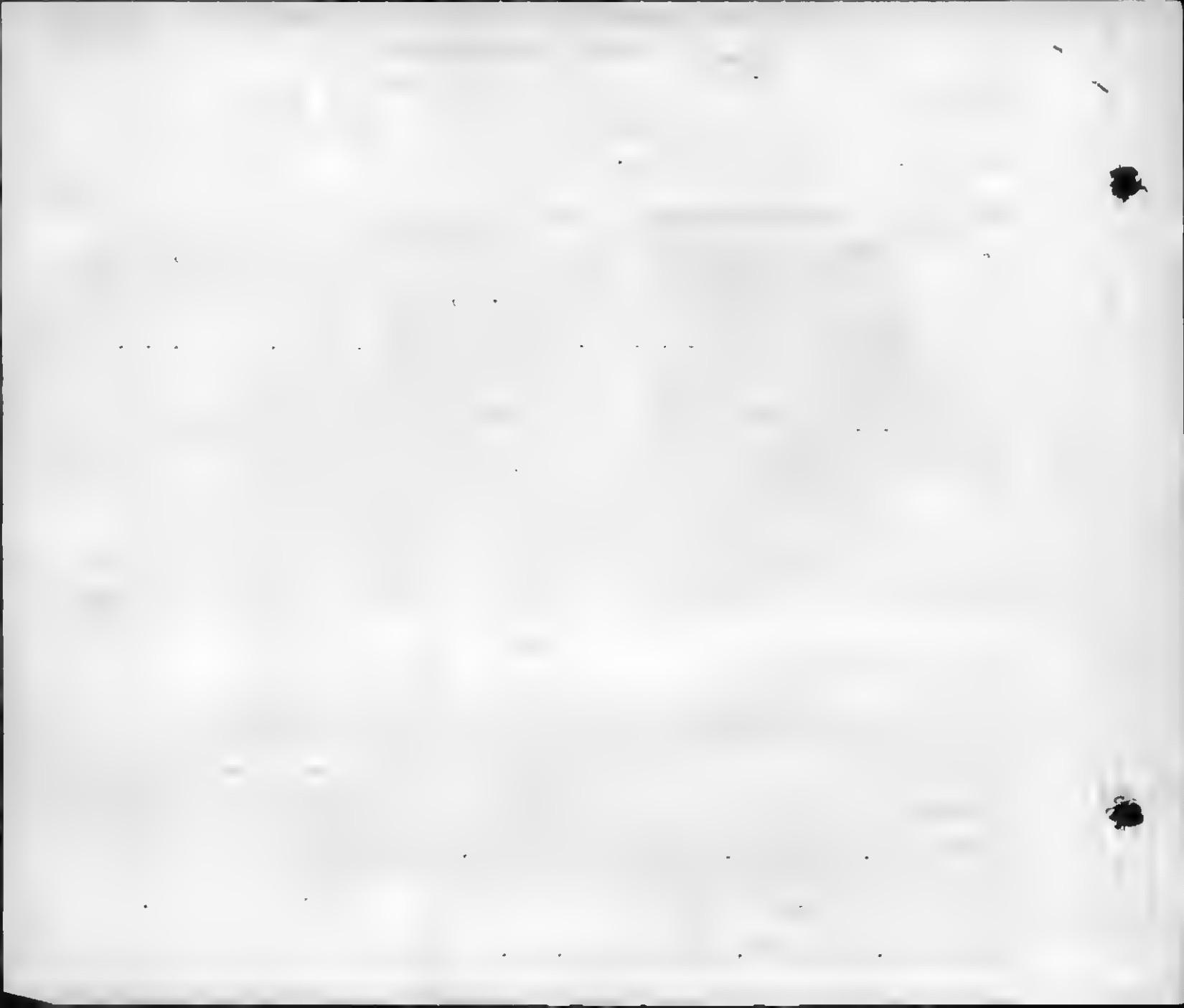
00951

CERTIFICATE OF DEATH

Reg. Dist. No.

797

1. PLACE OF DEATH Montgomery COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Maryland STATE		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 4 yrs.		d. STREET ADDRESS 11706 Rockinghorse Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11706 Rockinghorse Road							
3. NAME OF DECEASED (Type or print)	First MARIE	Middle ROSE	Last THERESA	4. DATE OF DEATH January 12, 1959	Month January	Day 12	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1890	9. AGE (In years less birthday) 68 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Hours 7	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cisto Rossetti		14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> NO <small>(If yes, give war or dates of service)</small>		16. SOCIAL SECURITY NO. None		17. INFORMANT Anthony Vincent - as shown in #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 1 hr	
(b) DUE TO Atrial fibrillation						20 years	
(c) Diseases, including						15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 615 W Maryland Ave		20f. (City or town) (County) (State) Silver Spring, Md. MD	
21. I certify that I attended the deceased from <u>Oct</u> , 1954, to <u>12 Jan</u> , 1959, that I last saw the deceased alive on <u>12 Jan</u> , 1959, and that death occurred at <u>12:06 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. William S. Murphy		ADDRESS 615 W Maryland Ave		ADDRESS (Street, city or town, state) 615 W Maryland Ave		DATE SIGNED 12 Jan 59	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-59		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven		22d. LOCATION (City, town, or county) Silver Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda		ADDRESS 14, Md.		24a. REC'D BY REGISTRAR JAN 14 '59		24b. REGISTRAR'S SIGNATURE S. M. S. M.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 1-2-9 et

00952

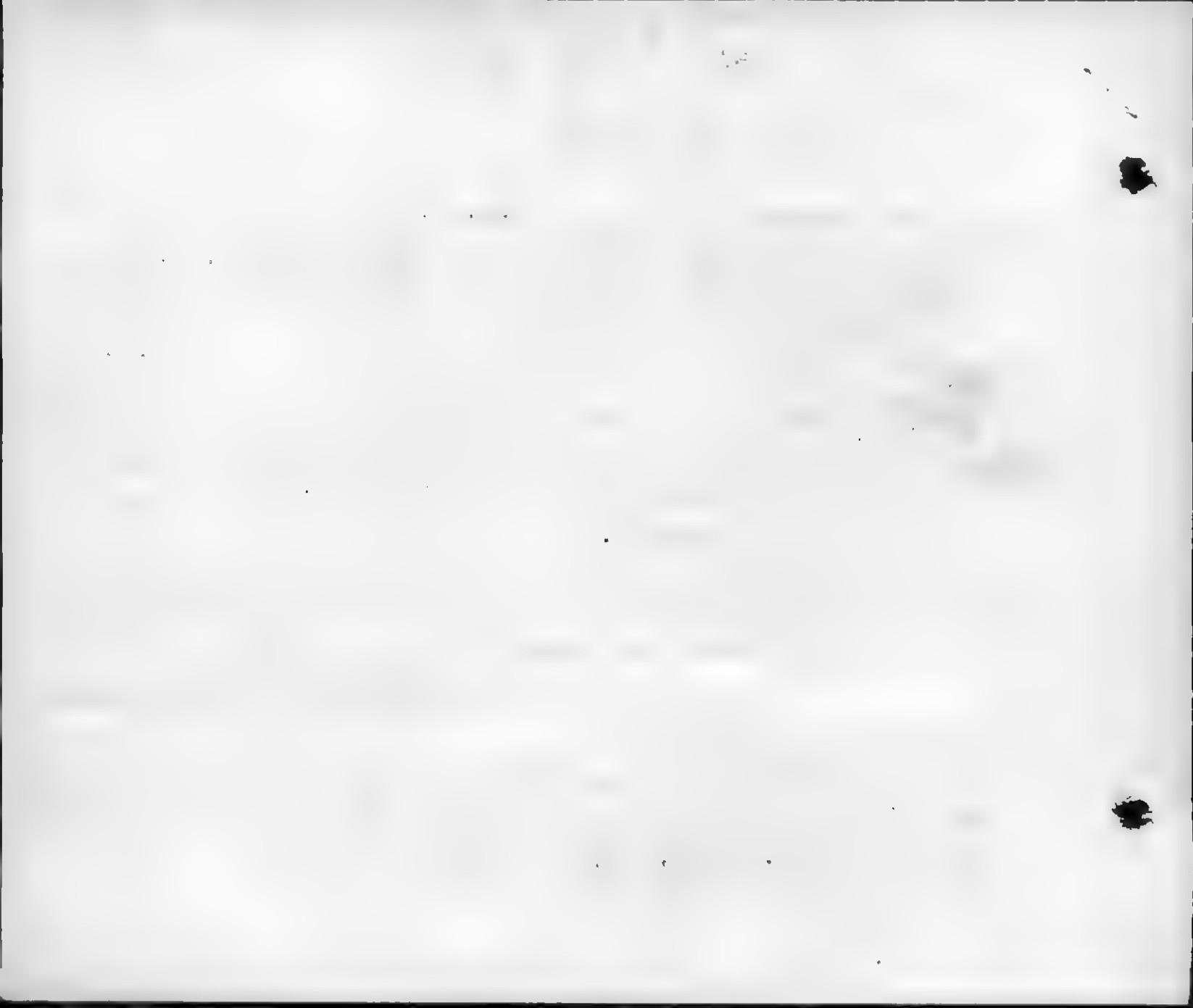
949

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Pennsylvania		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Brady		d. STREET ADDRESS R. D. #1, Box 211		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John Andrew Vogt		First	Middle	Last	4. DATE OF DEATH JANUARY 20, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1943	9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Homer Vogt				14. MOTHER'S MAIDEN NAME Thelma Seybert				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO hemorrhage. (c)								
19. INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 19, 1959 to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 11:00 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Charles A. Bucknam		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1-20-59						
PHYSICIAN'S NAME (Type) Charles A. Bucknam, M.D.		The National Institutes of Health Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59		22c. NAME OF CEMETERY OR CREMATORIAL E. Grady Pa. Cem.		22d. LOCATION (City, town, or county) (State) E. Grady, Pennsylvania		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE Cushing L. G. Jr.		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00953

950

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stafford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS RR #2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle (none)	Last WALTERS	4. DATE OF DEATH	Month January	Day 23	Year 19 59
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-86	9. AGE (In years less birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Joseph WALTERS				14. MOTHER'S MAIDEN NAME Marie (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 1908-1935		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Congestive heart failure. Hyper tension Cardiovascular Disease</i>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Total debilitation for advanced Coronary of heart 1959</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <i>19</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, NNM		20f. (City or town) (County) (State) Arlington	
21. I certify that I attended the deceased from January 14, 1959 , to January 23, 1959 , that I last saw the deceased alive on January 22, 1959 , and that death occurred at 4:20A M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM DATE SIGNED 1-23-59							
ACTUAL SIGNATURE <i>[Signature]</i>							
PHYSICIAN'S NAME (Type) M. C. SHEA, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey Funeral Home, Bethesda, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Pumphrey</i>	



1 D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00954

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by the funeral director. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return even within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg.		Reg. Dist. No.				
b. CITY OR TOWN (If out side corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 30 yrs		c. CITY OR TOWN (If out side corporate limits, write RURAL and give nearest town) Takoma Park						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7324 Willow Ave.		d. STREET ADDRESS 7324 Willow Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Roy Everett Walters		First	Middle	Last	4. DATE OF DEATH Jan. 7, 1959	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1884	9. AGE (in years on birthday) 74	IF UNDER 16 YRS Months	Days	IF UNDER 24 HRS Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Geo. Washington Walters		14. MOTHER'S MAIDEN NAME Grimm		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		16. SOCIAL SECURITY NO		17. INFORMANT Irene S. Walters (wife)		Item 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 1/8/59
EXAMINER'S NAME (Type) Frank J. Broschart		22a. BURIAL, CREMATION, ETC. REMOVAL (Specify) CREMATION		22b. DATE THREE OF REMOVAL 1/9/59		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM		22d. LOCATION (City, town, or county) PRINCE GEORGE County, Md.		(State)
23. FUNERAL DIRECTOR SIGNATURE <i>John J. Halligan</i>		ADDRESS 254 CARROLL ST. N.W.		24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

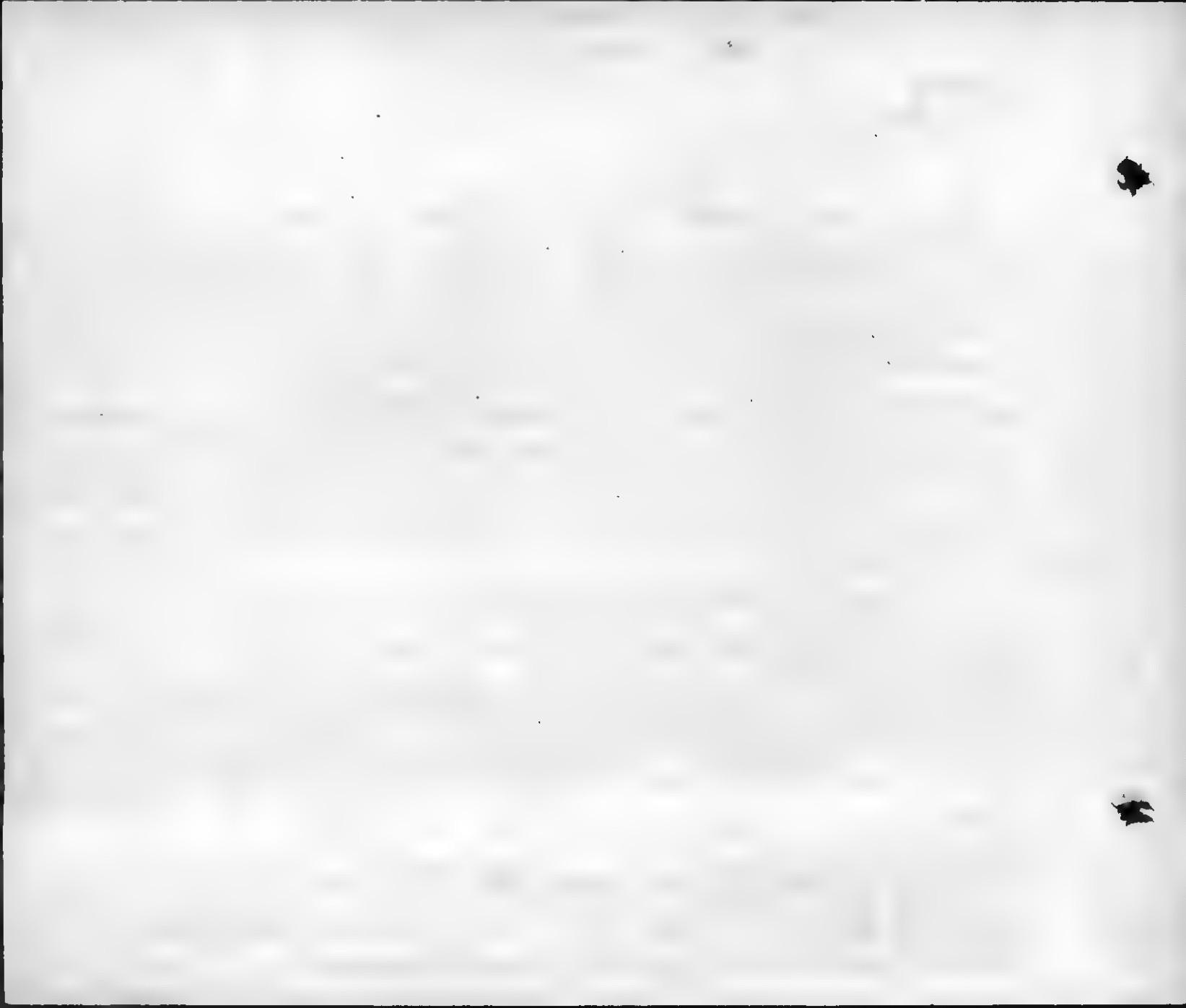
00955

788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN lb 11		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>313 Estevan Avenue, Inc.</i>		d. STREET ADDRESS <i>313 Estevan Avenue, Inc.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MAU</i>	Middle <i>WILKINS</i>	Last <i>WARDLE</i>	4. DATE OF DEATH <i>Jan. 4 1959</i>	Month Year	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 8 - 1878</i>	9. AGE (in years last birthday) <i>80</i>	10. IF UNDER 1 YEAR Months <i>80</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Wilkins</i>		14. MOTHER'S MAIDEN NAME <i>Hymans</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mrs. Estevan Woods - 313 Estevan Avenue</i>		Address <i>Takoma Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of cervix</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>			
21. I certify that I attended the deceased from _____ 1954, 19, to _____ 1/4, 1959, that I last saw the deceased alive on _____ 1/2, 1959, and that death occurred at 7 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>M.D. 3900 McKinley St. N.W.</i>	
ACTUAL SIGNATURE <i>Irving W. Winik</i>						DATE SIGNED <i>1/15/59</i>	
PHYSICIAN'S NAME (Type) <i>Irving W. Winik</i>							
22a. FORM OF CREMATION <i>Cremation</i>		22b. DATE THEREOF <i>Jan 6, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Good Shepherd Cemetery</i>		22d. LOCATION (City, town, or county) <i>Prince George County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter J. Kelly</i>		ADDRESS <i>254 Carroll St. N.W.</i>		24a. REC'D BY REGISTRAR <i>D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Kline</i>	
				DATE 1/7 '59			



00956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designee agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montg.		Reg. Dist. No.			
Montgomery MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
b. LENGTH OF STAY IN 1b 8 yrs		e. STREET ADDRESS 309 Frederick Ave., Lincoln Pk.		f. IS RESIDE CT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Frederick Ave., Lincoln Pk.		g. DATE OF DEATH Jan 15, 1959		h. Month Day Year Jan 15, 1959			
3. NAME OF DECEASED (Type or print)		First Peter	Middle Washington	Lost	Month	Day	Year
3. SEX male		6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1880	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY Divine Healer		11. BIRTHPLACE (State or foreign country) D.C.			
13. FATHER'S NAME Peter Washington		14. MOTHER'S MAIDEN NAME Elizebeth Powell		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Laura Washington (Wife) Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X		Respiratory Failure		8 Mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Cerebral Vascular Accident					
DUE TO (b)		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 16, 1859	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/59		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park.,		22d. LOCATION (City, town, or county) Rockville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 21 1959		24b. REGISTRAR'S SIGNATURE <i>Robert L. Saunders</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00958

951 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co. Tokoma</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 517 Albany Avenue		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Tokoma Park</i>		d. STREET ADDRESS <i>3702 Perry St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>A.</i>	Last <i>Wells</i>
4. DATE OF DEATH	Month <i>January</i>	Day <i>36</i>	Year <i>1959</i>
5. SEX	6. COLOR OR RACE <i>Male white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 22, 1866</i>
9. AGE (In years last birthday) <i>92 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cool Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY 11. PLACE (State or foreign country) <i>Iowa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Daniel Wells</i>		14. MOTHER'S MAIDEN NAME <i>Emma C Sisson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unk.</i>	
17. INFO <i>Miss Anna Peg</i>		Address <i>518 Carroll Ave NW</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>6-41</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Ma.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 19</i> , 1959, to <i>Jan 26</i> , 1959, that I last saw the deceased alive on <i>Jan 26</i> , 1959, and that death occurred at <i>2:27 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Philip E. Jones</i> M.D. <i>918 Ellsworth Drive</i> <i>1-26-59</i>	
ACTUAL SIGNATURE <i>Philip E. Jones</i>		DATE SIGNED <i>Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-28-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Whitfield Cemetery</i>	22d. LOCATION (City, town or county) <i>Bethesda</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Harsh's Sons</i>		ADDRESS <i>Hughesville, Md.</i>	24a. REC'D BY REGISTRAR DATE JAN 27 1959
			24b. REGISTRAR'S SIGNATURE <i>J. Harsh's Sons</i>

مکالمہ کیا تھا اس سے تجھے کیا
لگائیں گے اس سے تجھے کیا لگائیں گے

لگائیں گے اس سے تجھے کیا لگائیں گے
لگائیں گے اس سے تجھے کیا لگائیں گے

لگائیں گے اس سے تجھے کیا لگائیں گے

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

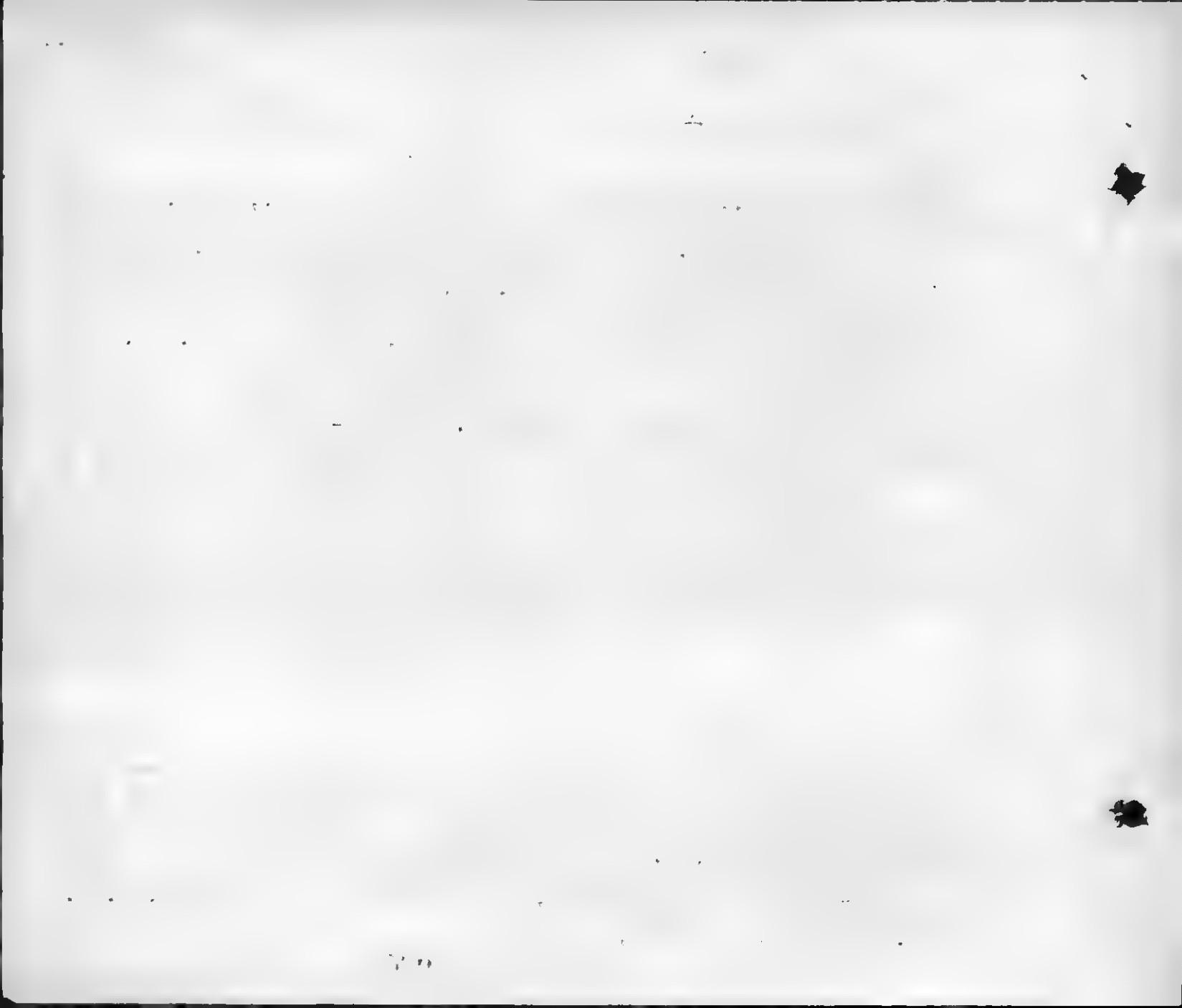
952

CERTIFICATE OF DEATH

00959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 3 years		d. STREET ADDRESS 4712 Edgefield Rd., Beth.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4712 Edgefield Rd., Bethesda									
3. NAME OF DECEASED (Type or print) Sarah M. Wheeler		First	Middle	Last	4. DATE OF DEATH Jan. 1, 1959	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1872	9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR 11 mos.	11. IF UNDER 24 HRS 19 hours	12. Hours	13. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harmanus Bennett		14. MOTHER'S MAIDEN NAME Marion Collie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Marion S. Brooks - as above #2 Daughter		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO pulmonary congestion, acute		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Arteriosclerosis		DUE TO Arteriosclerosis		20 yrs.					
DUE TO (b)									
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) Montgomery (State) Maryland	
21. I certify that I attended the deceased from 2 February, 1958 to 1 January 1959 that I last saw the deceased alive on 31 Dec, 1958 , and that death occurred at 12:05 PM , from the causes and on the date stated above. ACTUAL SIGNATURE John M. Wyman								ADDRESS (Street, city or town, state) M.D. 7659 Old Georgetown Road Bethesda, Maryland	DATE SIGNED 1/2/59
PHYSICIAN'S NAME (Type) John M. Wyman, M. D.									
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 1-6-59		22c NAME OF CEMETERY OR CREMATORIUM Greenfield, Long Island - Long Island, N. Y.		22d LOCATION (City, town, or county) (State)			
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		24a REC'D BY REGISTRAR DATE JAN 5 '59		24b REGISTRAR'S SIGNATURE			



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

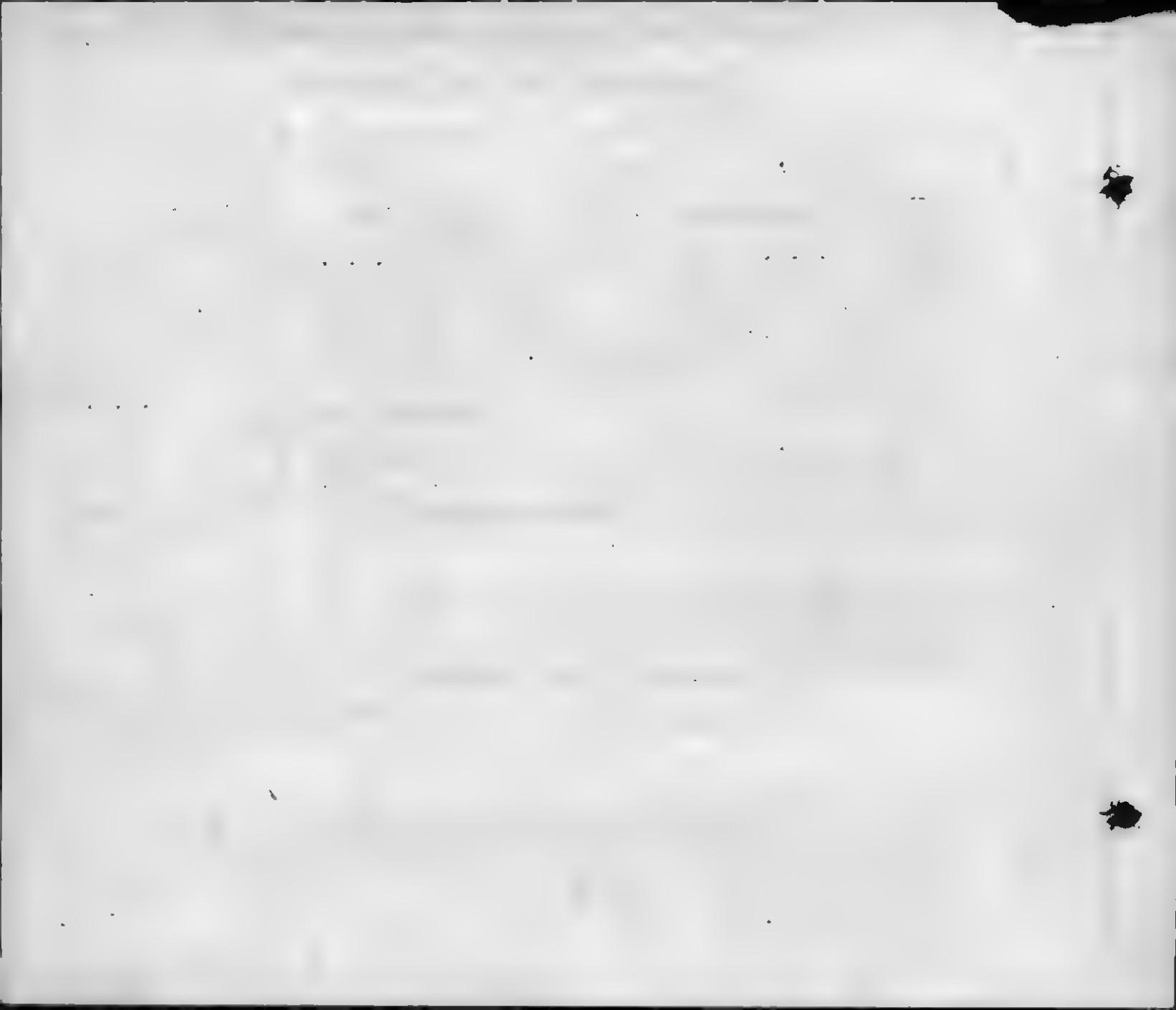
00960

CERTIFICATE OF DEATH

953

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural	MARYLAND Length of Stay (in this place) Life	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural	COUNTY Montgomery Gaithersburg
HOSPITAL OR INST TUT. ON OR STREET ADDRESS R.F.D. # 1	/ STREET ADDRESS R.F.D. # 1	Live On Farm	
3. NAME OF DECEASED (First) MARY (Middle) WALTER (Last) WIGHTMAN		4. DATE OF DEATH (Month) Jan. 21 (Day) 19 59 (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 11 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 84 yrs.
13. FATHER'S NAME Howard H. Kinsey		14. MOTHER'S MAIDEN NAME Margaret Parsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Clifton Wightman Same As
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic cardiovascular disease</i></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</p>			
INTERVAL BETWEEN ONSET AND DEATH 5 days - 15 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....6/12....., 19 49, to.....1/21....., 19 59, that I last saw the deceased alive on.....1/18....., 19 59, and that death occurred at.....M., from the causes and on the date stated above. SIGNATURE <i>James P. Kerr M.D.</i> M.D. ADDRESS (Street, city, town, state) <i>Jameson, Md.</i> DATE SIGNED <i>1/23/59</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Jan. 24	NAME OF CEMETERY OR CREMATORIUM Goshen	LOCATION (City, town, or county) Goshen (State) Md.
24. REC'D BY REGISTRAR DATE JAN 26 '59	REGISTRAR'S SIGNATURE <i>John L. Hayes</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W. Barber Laytonsville</i> ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00961

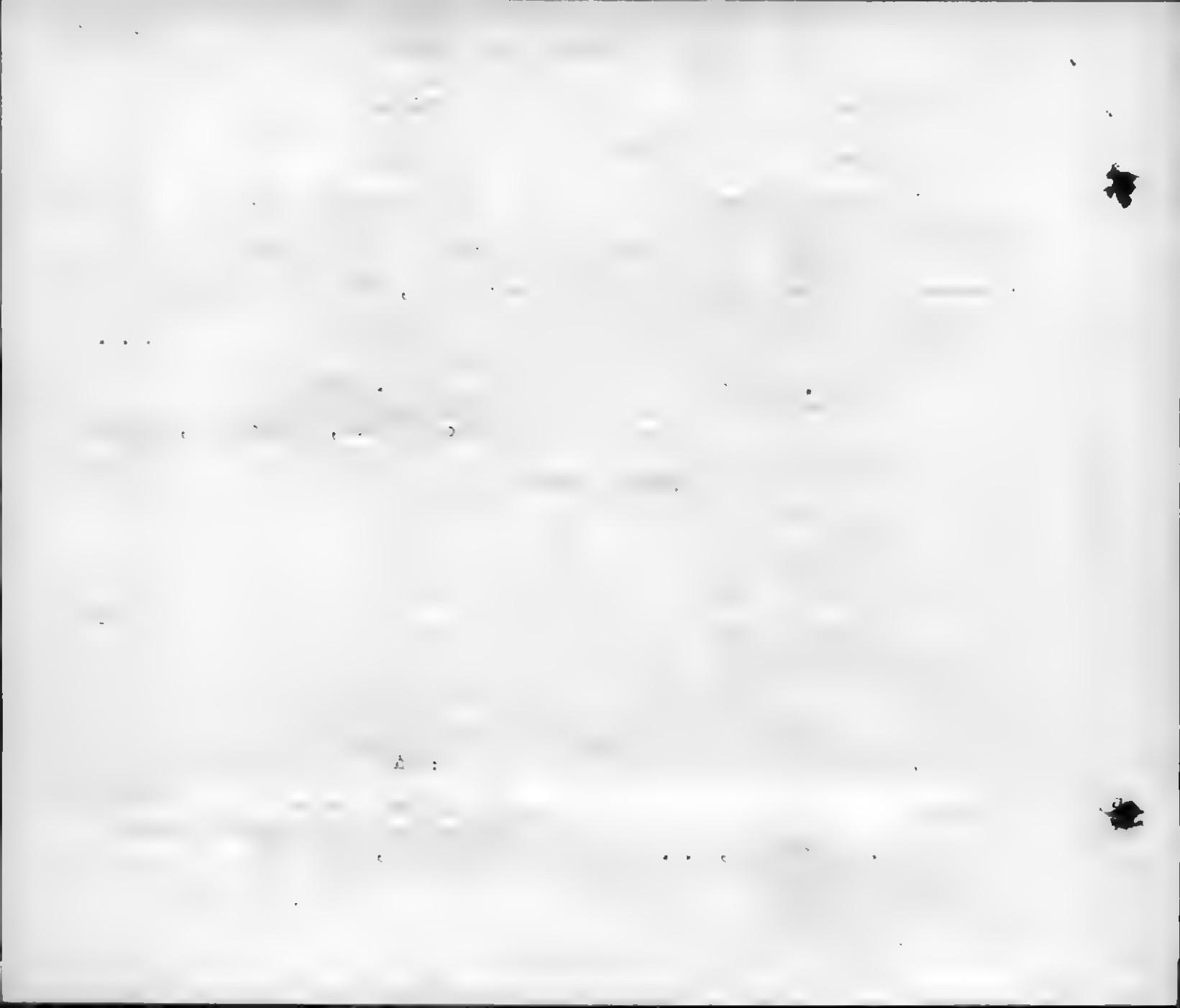
954 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Michigan		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bay City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 252 State Park Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kim	Middle Anne	Last Wilcox	4. DATE OF DEATH January 26, 1959	Month January	Day 26	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1958	9. AGE (In years lost birthday) yrs. 11	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS Hours 4	12. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Merle J. Wilcox		14. MOTHER'S MAIDEN NAME Kay B. Schulz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aplastic Anemia DUE TO 242.4 Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1959 , to January 26, 1959 , that I last saw the deceased alive on January 26, 1959 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE G. Richard Lee, M.D.		M.D.		DATE SIGNED 1/26/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 1/27/59		22c. NAME OF CEMETERY OR CREMATORIUM Maple Grove		22d. LOCATION (City, town, or county) (State) Empire, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 28 1959		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00962

789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>WASH. D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—end give nearest town <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>25 1/2 Hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium & Hospital</i>		d. STREET ADDRESS <i>4442-TINDALL ST. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Agnes</i>	Middle <i>Sophia</i>	Last <i>Will</i>	4. DATE OF DEATH	Month <i>1</i>	Day <i>- 19</i>	Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5-1-79</i>	9. AGE (In years lost birthday) <i>79</i> yrs.	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS Days <i>18</i>	Hours <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>P. Will</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Watson</i>		Address <i>Hospital Records</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No—Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>33IX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Arterosclerosis</i> (c) <i>Cerebral Circulatory Arrest</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		INTERVAL BETWEEN ONSET AND DEATH <i>in... 11</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Hour a.m. p.m. 19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>Robert A. Howard, Informant</i>		PHYSICIAN'S NAME (Type) <i>Robert A. Howard, Informant</i>					
22a. BURIAL, Cremation <i>BURIAL</i>	22b. DATE THEREOF <i>1-21-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Congregational</i>	22d. LOCATION (City, town, or unit) <i>55 E. 8th St. Wash. DC</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Hyung Co.</i>	ADDRESS <i>1300-N.E. N.W.</i>	24a. REC'D BY REGISTRAR <i>DATBAN 20 '59</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2100 36 81 381
Keweenaw
Michigan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 mG238 1-23-51 et

00963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammon's Rest Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Lula	Middle Williams	Last Loss	4. DATE OF DEATH	Month January	Day 8,	Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 16, 1891	9. AGE (In years lost/birthday yrs.) 67	11. IF UNDER 1 YEAR Months 6	12. IF UNDER 24 HRS Days 1	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? Rockville, Md.		
13. FATHER'S NAME Singleton Brown		14. MOTHER'S MAIDEN NAME Laura Simms						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Estelle Palmer				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetic Acidosis & Dehydration DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Carcinoma of the Breast (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiorenal Disease								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Norbeck, Md.	(County) Montgomery Co.	(State) Md.
21. I certify that I attended the deceased from Nov. 12, 1945 , to Jan. 8, 1959 , that I last saw the deceased alive on Jan. 8, 1959 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck, Md.								
ACTUAL SIGNATURE <i>Webster Sewell</i>	DATE SIGNED Jan 15 1959							
PHYSICIAN'S NAME (Type) Webster Sewell	Norbeck, Rt. 1 Silver Spring, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Pleasant,,	22d. LOCATION (City, town, or county) Norbeck, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swindler</i>	ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR JAN 15 '59		24b. REGISTRAR'S SIGNATURE <i>Webster Sewell</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 shall be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, in any event within 72 hours after death.



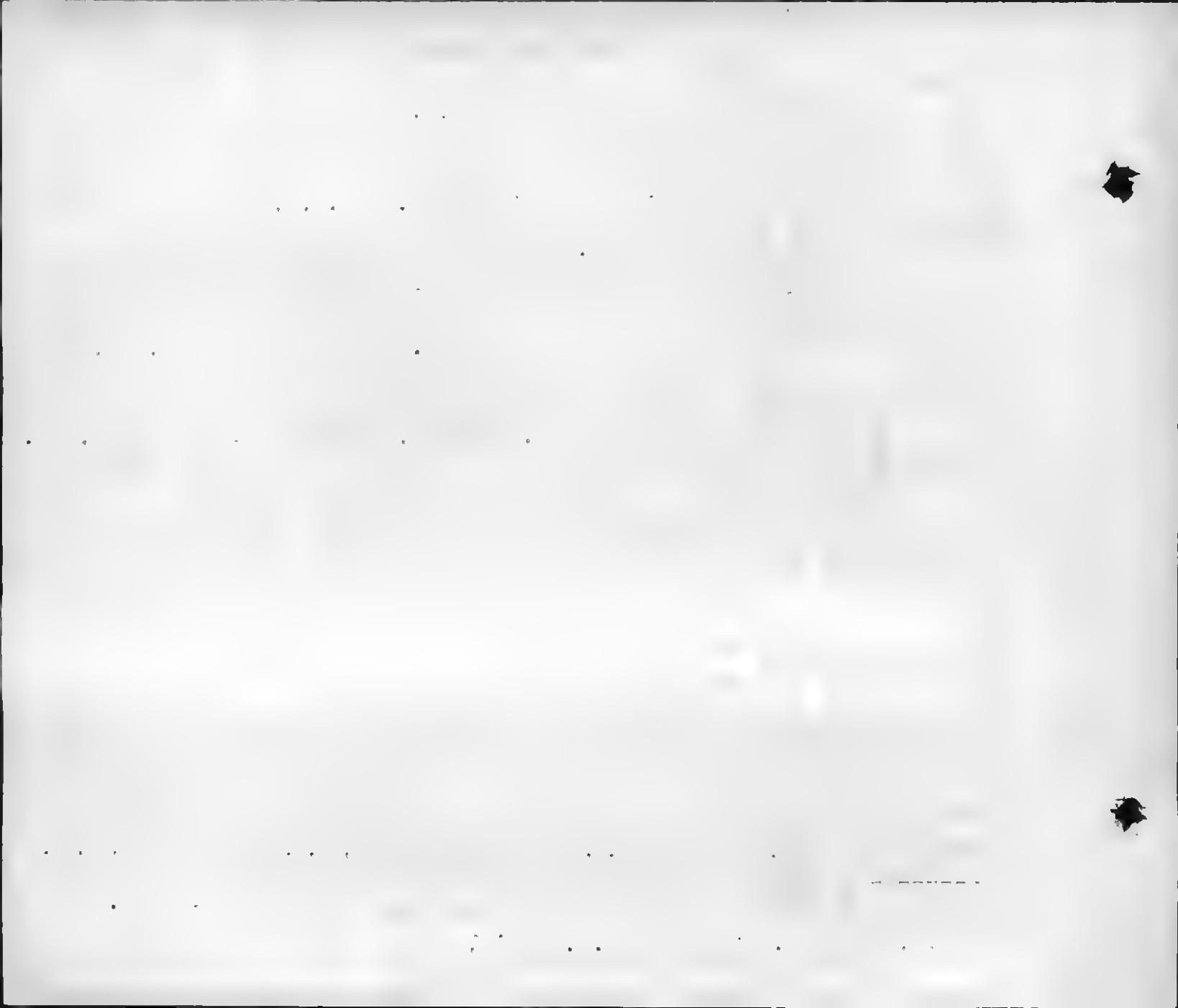
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00964

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		956		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
Montgomery MARYLAND				a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b.		b. COUNTY	
Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
Kensington Garden Sanitarium		Apt 1037 4201 Mass. Ave. N.W.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Daisy	Middle B.	Last Wooten	4. DATE OF DEATH January 31 Month Year 19 59
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1883	9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				Miss.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Vincey Brister		14. MOTHER'S MAIDEN NAME Julia Sutton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lynell W. Littlefield, 4201 Mass. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X		Metastatic Carcinoma of Endo Cervix Prob. 4 years.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Terminal Congestive Heart failure			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 16</u> , 1957, to <u>Jan. 31</u> , 1959, that I last saw the deceased alive on <u>Dec. 29</u> , 1959, and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Leland E. Stevenson</u>		M.D. <u>2101-R St. N.W. - D.C. 8</u>			
PHYSICIAN'S NAME (Type)		Loland E. Stevenson, M.D. 2101 R Street, N.W., Washington 8, D. C.			
22a. FUNERAL ORGANIZATION REMOVAL (Specify) removal		22b. DATE THEREOF 1/31/59		22c. NAME OF CEMETERY OR CREMATORIAL Roseland Park Cemetery Hattiesburg, Miss.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. 2901 14th St. N.W. Wash,		ADDRESS D.C.		24a. REC'D BY REGISTRAR DATE FEB 2 '59	
				24b. REGISTRAR'S SIGNATURE <u>Leland E. Stevenson</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 51-7229 3-9-4 et

00965

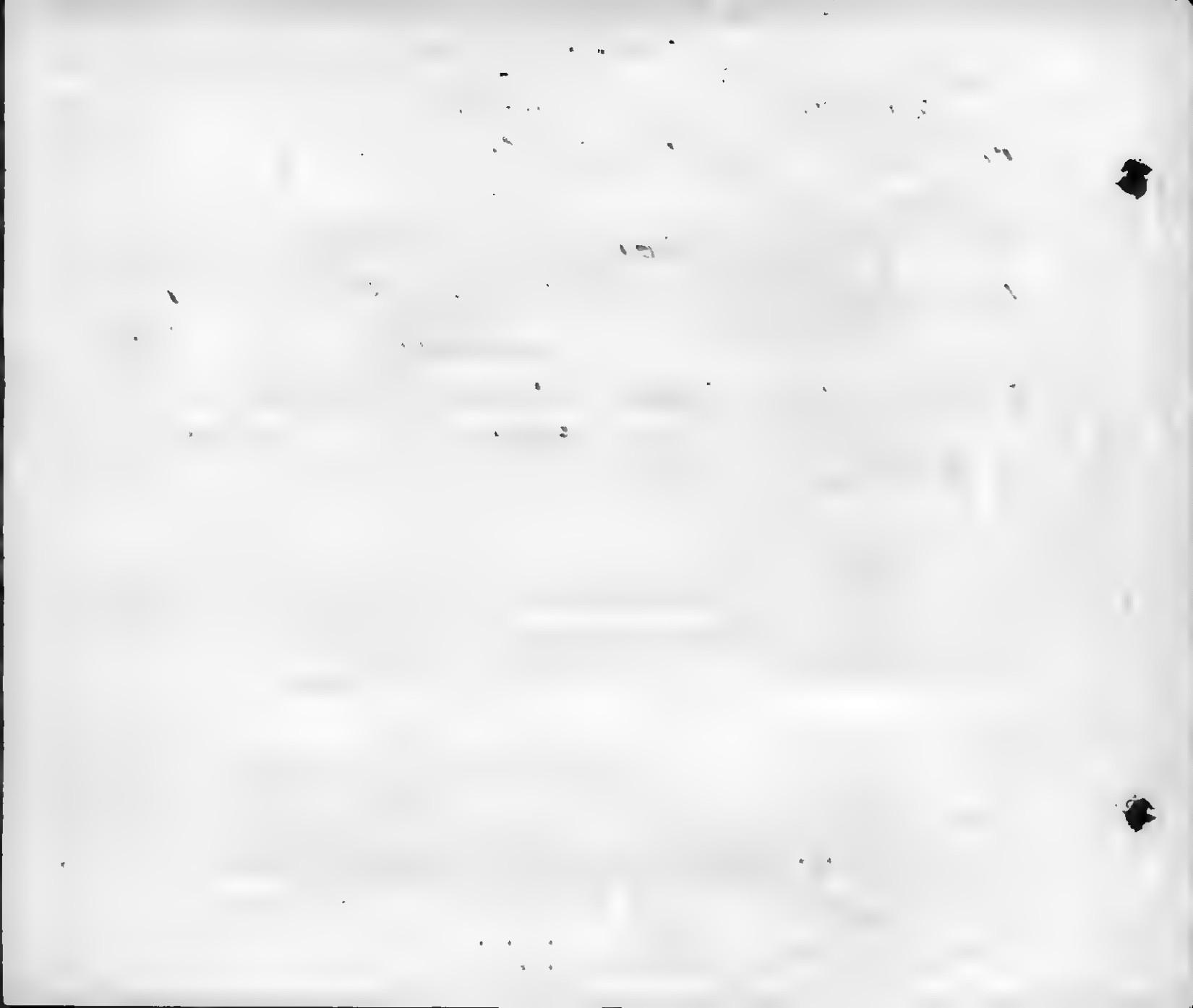
957

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 21 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GATHERS BURG	
3. NAME OF DECEASED (Type or print) Bruce Roy First BRYAN WORKINGER		Middle LAST	4. DATE OF DEATH Month JAN Day 19 Year 1959
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JANUARY 27, 1989		9. AGE (In years last birthday) yrs. 19	10. IF UNDER 1 YEAR Months 1 Days 0 Hours 0 Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE RAY WORKINGER		14. MOTHER'S MAIDEN NAME ELAINE M. ERICKSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT FATHER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 116X DUE TO Drenatitity INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO — (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tone		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 27, 1959 , to Jan 27, 1959 , that I last saw the deceased alive on Jan 28, 1959 , and that death occurred at 6:23 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rockville Medical Center, Rockville, Md. DATE SIGNED 1-28-59	
ACTUAL SIGNATURE R.H. Bergstrom		PHYSICIAN'S NAME (Type) R.H. Bergstrom Rockville Medical Center Rockville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-6-59	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home		24a. ADDRESS 4748 Wisconsin Ave. N.W.	24b. REC'D BY REGISTRAR FEB 3 '59
		24c. REGISTRAR'S SIGNATURE Oliver S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00966

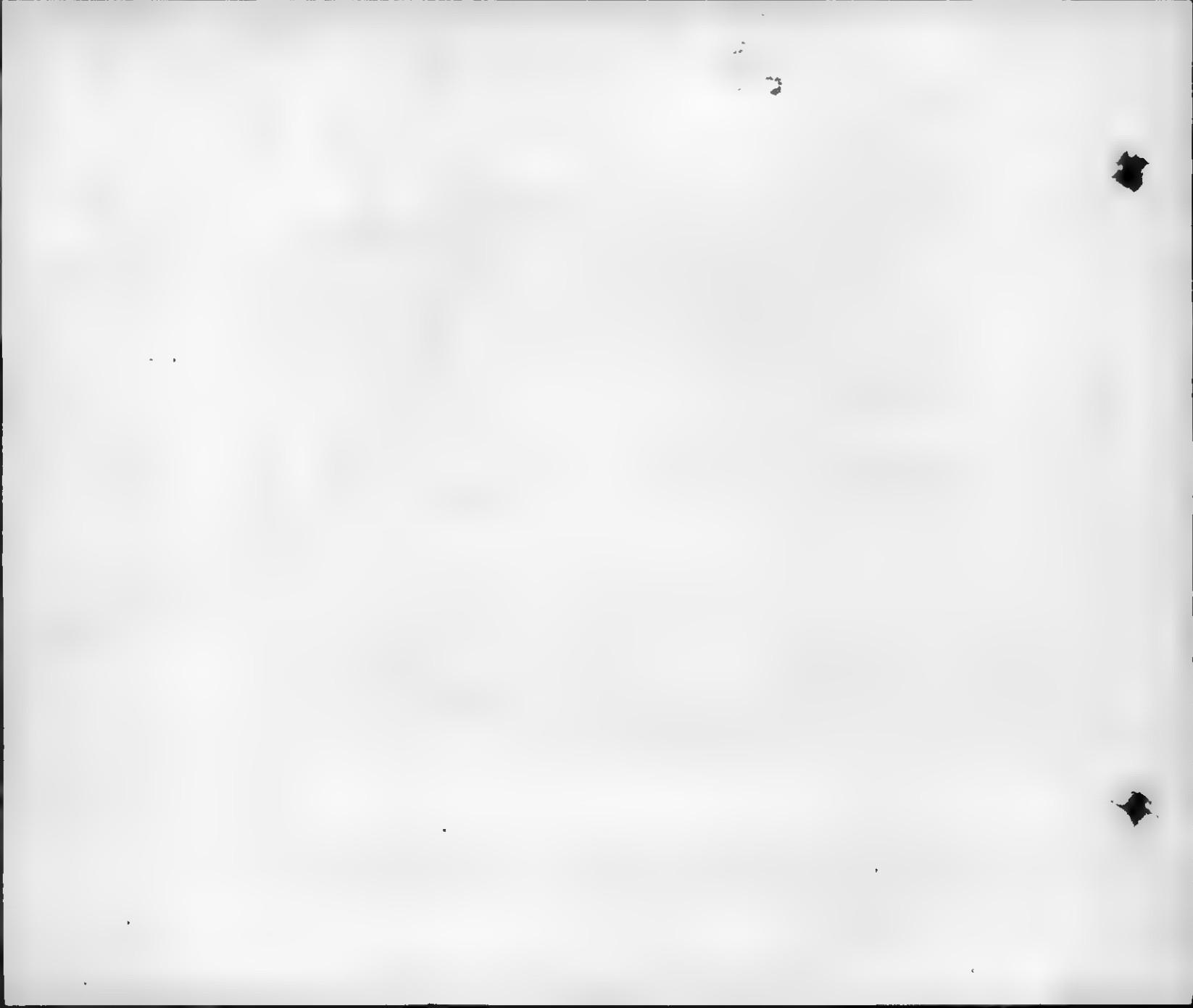
CERTIFICATE OF DEATH

Reg. Dist. No. 215

958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		If institution Residence before admission b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun						
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Kepple Hills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Karen	Middle Frances	Last WORLAND	4. DATE OF DEATH	Month January	Day 16	Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-5-59	9. AGE (In years lost birthday) yrs 11	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 11	Hours 00	Min 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bainbridge, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME Wallace WORLAND				14. MOTHER'S MAIDEN NAME Louise PRESLEY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Indirect oropharyngeal fistula DUE TO 156.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 11 days.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from January 7, 1959 , to January 16, 1959 , that I last saw the deceased alive on January 16, 1959 , and that death occurred at 10:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. J. Rupnik M.D. U. S. Naval Hospital ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 1-17-59										
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-59		22c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery		22d. LOCATION (City, town, or county) Cecil Co. (State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR Arthur S. Trahan		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan				
						DATE JAN 20 '59				



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

00961

959 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>							
				b. COUNTY <i>Montgomery</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>112817 Georgia Ave</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12817 Georgia Ave</i>				d. STREET ADDRESS <i>112817 Georgia Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Viola French Youmans</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan 7 1959</i>	Month	Day	Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Mar 19, 1883</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMEMAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Wisc</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Ciarion A. Youmans</i>		14. MOTHER'S M AIDEN NAME <i>Nettie ROSE French</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Beth Y. Sturdevant</i>		Address <i>Silver Spring Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> (b) DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>10110 Georgia Ave</i>		(County) <i>Silver Spring</i>	(State) <i>Md</i>		
21. I certify that I attended the deceased from <i>Nov 7, 1958</i> , to <i>Jan 7, 1959</i> , that I last saw the deceased alive on <i>Jan 7, 1959</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Lawrence Avery</i> M.D. <i>10110 Georgia Ave Jan 7 '59</i> PHYSICIAN'S NAME (Type) <i>John Lawrence Avery</i> ADDRESS (Street, city or town, state) <i>Silver Spring, Maryland</i> DATE SIGNED											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>1/10/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLN CREMATORIAL</i>		22d. LOCATION (City, town, or county) <i>PRINCE GEO. COUNTY, MD.</i>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>Office of the Registrar</i>			24b. REGISTRAR'S SIGNATURE <i>Office of the Registrar</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01 JOURNAL - REVENUE STATEMENT

1940 TO 1941

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VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
960 CERTIFICATE OF DEATH

00968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3312 W. Coquelin Terrace				d. STREET ADDRESS 13312 W. Coquelin Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Desmonde		First	Middle	Last	4. DATE OF DEATH Jan 15 1959	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/80		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ---Harding				14. MOTHER'S MAIDEN NAME ---Coles				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT C. Harding Zimmisch		Address same as 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO <i>Cerebral Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerosis</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congestive heart failure</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>None</i> -19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1/13</i> , 19 <i>58</i> , to <i>present</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/13</i> , 19 <i>59</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>John B. Umhoefer M.D.</i> ADDRESS (Street, city or town, state) <i>8805 Conn. Ave. Chevy Chase 15 Md.</i> DATE SIGNED <i>1/13/59</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/17/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i>		24a. REC'D'D BY REGISTRAR <i>JAN 19 1959</i>		24b. REGISTRAR'S SIGNATURE <i>John B. Umhoefer</i>		

3. DOCUMENT NUMBER: 00000000000000000000

17:20 10-27-2019